S. HRG. 104–27

CONSOLIDATION AND REAUTHORIZATION OF HEALTH PROFESSIONS PROGRAMS

HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

ON

EXAMINING PROPOSED LEGISLATION AUTHORIZING FUNDS FOR THE HEALTH PROFESSIONS PROGRAMS OF THE PUBLIC HEALTH SERVICE ACT, FOCUSING ON THE CURRENT STATUS OF THE HEALTH PROFESSIONS AND THE FEDERAL ROLE IN THIS AREA

MARCH 8, 1995

Printed for the use of the Committee on Labor and Human Resources

U.S. GOVERNMENT PRINTING OFFICE
89–050 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-047196-6

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WEDNESDAY, MARCH 8, 1995

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Nancy Landon Kassebaum (chairman of the committee) presiding.

Present: Senators Kassebaum, Jeffords, Frist, DeWine, Abraham, Gorton, Kennedy, and Wellstone.

The CHAIRMAN. The committee will come to order.

I will wait to give an opening statement, because I know that Senator Hatfield has to go to the floor, where he is the floor leader for the defense supplemental appropriation bill. But I am so pleased that he could take the time to come and be our first witness this morning, because there is no one in the Senate who has been a stronger voice for health, public health, research in medicine and has been a stalwart in this through the years.

So it is a great pleasure to welcome you as our star witness, Senator Hatfield.

STATEMENT OF HON. MARK O. HATFIELD, A U.S. SENATOR FROM THE STATE OF OREGON

Senator HATFIELD. Thank you, Senator Kassebaum.

It is a privilege to be here once again on behalf of education and to be working with you on some monumental legislation.

I want to commend you first of all for your proposal that is being considered by this committee of putting forward the first step in streamlining Federal administration of the programs authorized under Titles III, VII, and VIII of the Public Health Service Act.

Madam Chairman, I just want to highlight and emphasize some detailed points, but I would appreciate my full statement appearing in the record as if given.

The CHAIRMAN. Without objection, it will be.

Senator HATFIELD. Need I say that as a member of the Appropriations Committee and its current chairman, that for the last 10 years, the Appropriations Committee has appropriated almost $3 billion to fund the Federal health professions education programs. The purpose of these programs is to improve the quality and supply and distribution of health providers and to advance the training and retention of minorities in the health professions.

In the early 1990's, Congress increased funding to these programs to expand efforts to train more primary care providers, as

you know, and address the shortages in rural and underserved areas. But despite these efforts, a recent General Accounting Office report stated the results are inconclusive due to the lack of data or inconsistent data. For the amount of money we have appropriated for these programs, the lack of evaluation is unacceptable, from my perspective.

I applaud you, Madam Chairman, for addressing this problem in your reauthorization proposal. As we face an ever-shrinking amount of discretionary funds, we must be assured that appropriated funds are advancing the purposes of underlying authorizing legislation.

Of the 45 programs authorized by these three titles of the Public Health Service Act, the Appropriations Committee currently funds 36 separate health professions education programs. The chairman's proposal would consolidate these 36 programs into six clusters, streamlining authorizations and appropriations and providing more flexibility to meet the purposes of these programs. This consolidation would reduce the Federal bureaucracy needed to administer the programs.

More importantly, this proposal would include a national goal for the health professions education programs. In addition, it would provide a mechanism for evaluating how well these programs are doing to meet that goal. By clarifying the purpose and perhaps even narrowing the current focus of the program, this proposal would better ensure that program funds are making a difference.

Much of my own knowledge of the health professions education programs derives from the experiences of my own State of Oregon which has had these programs. In August of 1993 and April of 1994, the Appropriations Subcommittee on Labor, Health and Human Services, and Education held field hearings in Oregon to examine our rural health care needs, with particular focus on the shortage of health professionals. In both hearings, it became clear that the need to recruit and retain health professionals in rural areas is an ever-present concern.

For example, a large percentage of rural physicians are over 60 years old, and in a recent survey taken by the Oregon Office of Rural Health, 20 percent of these physicians indicated they intend to retire during the next 5 years. This means that Oregon must recruit about 300 new physicians during the next 5 years.

To put this into perspective, the Oregon Office of Rural Health is currently recruiting about 20 physicians a year, and Oregon has had a net increase of about 90 new physicians in rural Oregon since 1990.

Obviously, those figures prove that our current rate and our current record is not sufficient to meet the need and the future need, particularly.

Due to the leadership of the Oregon Health Sciences University, which includes the schools of medicine, nursing, and dentistry, we are beginning to make a difference by increasing numbers of students graduating in primary care and choosing to practice in rural areas.

I cannot overemphasize the necessity of getting our major institutions of learning, medical centers, as a part of the answer, as part of the solution, incorporating their resources. When they find

that by sending these students into some of their internships and some of their residencies and other parts of their educational programs, maybe in the first year, the second year, and they get exposed, and they get a place in a local community, a rural community, it is amazing how, in my view, these younger generations of medical students have had a great increase in social/medical consciousness. They face some very serious economic difficulties in the educational costs and the ability to recoup those costs and pay off their indebtedness. But in spite of all those obstacles, I think at least in my State we have seen—and I think this would probably be true in most States—that there is a newer dimension of comprehension and interest in social practice, in social/medical needs.

One of the reasons for this is a program funded through Title VII of the Public Health Service Act, which I strongly support, and that is the Area Health Education Centers program. By summer, every mile of the State of Oregon—and we are about 99,000 square miles—every mile of highway in the State of Oregon will be included in one of the five Area Health Education Centers, or AHECs. Since 1990, Oregon's AHECs have capitalized on a Federal, State and local community partnership to establish community-based training programs, including family practice, residencies, frontier nursing programs, rural rotations by current medical students, continuing education programs, using the distance learning systems made possible by the biomedical information communications center at Oregon Health Sciences University in Portland, and high school "Grow Your Own" programs.

Through this network of communication, which is one of the first in the Nation, I have seen demonstrations where, 300 miles from the city of Portland, a doctor with a patient is teaching a 4th-year class of medical students in Portland. I want to use that as an example that all of the knowledge and all of the resources are not in the urban center. There is much out there in the rural areas to enhance the urban centers. It is not just a matter of the urban centers, like a center of education, getting out and expanding their resources into rural areas; they are getting back in return resources that are important to their programs.

Second, I saw another example of a doctor moving into surgery 300 miles from Portland, with a camera and a monitor, getting consultation simultaneously at the Oregon Health Sciences University.

So I want to emphasize the importance of this kind of networking into rural America as a mutual benefit to both urban and rural.

I am pleased that the chairman has included Area Health Education Centers as a primary cornerstone of the community-based training in underserved areas cluster. I have several comments about this aspect of your proposal, Madam Chairman, which I hope you will consider as you develop it further.

First, it is my hope that you will retain the name, Area Health Education Centers, as the name of the entity into which other relevant training programs are merged, making that the umbrella agency. AHECS are well-known and well-respected throughout the country and the Congress. And second, non-Federal matching should be required of all of the programs merged with the AHEC program.

You see, the AHEC program today has always required matching funds, so that is nothing new with AHEC; and it has always required these from applicants in order to encourage a Federal-State partnership. When you are contributing, you are a full partner, and I think that that has been demonstrated through the AHEC.

Third, AHEC programs require leadership by major academic health centers if they are to have a significant impact within their respective States, as I have stated. I urge that priority be given to applicants from academic health centers, which include broad-based participation from each of the colleges involved in primary care educational programs.

And finally, primary care residency education will distribute more graduates into rural and underserved areas if the programs follow the AHEC concept of regionalization. That is another strength of AHEC is that there is a regional identity and a regional presence.

Thus, I recommend that a preference in funding be given to the primary care authority for applicants who are either sponsored by or have close affiliations with AHEC programs.

Generally, I support the other consolidations and changes suggested by the chairman. I would mention just two other issues.

Under the current proposal, general dentistry programs are included in the sixth cluster, I believe, the health professions work force development cluster. It is my hope that you will consider moving the general dentistry training program to the primary care and preventive medicine training cluster. It seems to fit there more appropriately, as 86 percent of general dentistry residents remain primary care providers.

As a strong supporter of nursing training and education programs, I am pleased to see the changes you have made, especially with regard to giving the Secretary more flexibility in funding innovative projects. I would just like to mention my hope that the National Advisory Council on Nurse Education and Practice will remain a primary advisory body to the Secretary regarding nursing issues.

I am pleased that the chairman has recognized the budget realities that we are facing in the Appropriations Committee and that authorized levels of funding must be reduced. The 10 percent reduction over 3 years of authorized levels is helpful to the Appropriations Committee. However, it is likely that the committee will be asked to make deeper cuts, and I think we have to face that possible reality. This is not a position I relish, especially in light of the shortages of health professionals we face in our rural and underserved areas, but I do appreciate the chairman's help.

Again, I appreciate the opportunity to be here this morning and to respond to your questions.

[The prepared statement of Senator Hatfield follows:]

PREPARED STATEMENT OF SENATOR HATFIELD

Madam Chairman, I appreciate the opportunity to testify before the Committee this morning concerning the consolidation of the Federal health professions education programs. The proposal you are putting forward is an important first step in streamlining federal administration of the programs authorized under Titles III, VII, and VIII of the Public Health Service Act.

As we in Congress work to make government work more effectively and efficiently, we must be willing to continually evaluate the programs we fund to assure that they are serving their purpose. For the last ten years, the Appropriations Committee has appropriated almost $3 billion to fund the federal health professions education programs. The purpose of these programs is to improve the supply and distribution of health providers and to advance the training and retention of minorities in the health professions. In the early 1990's Congress increased funding to these programs to expand efforts to train more primary care providers and address shortages in rural and underserved areas.

Despite these efforts, a recent General Accounting Office report stated the results are inconclusive due to the lack of data or inconsistent data. For the amount of money we have appropriated for these programs, this lack of evaluation is unacceptable. I applaud the Chairman for addressing this problem in her reauthorization proposal. As we face an ever-shrinking amount of discretionary funds, we must assure that appropriated funds are advancing the purposes of underlying authorizing legislation.

Of the 45 programs authorized by these three titles of the Public Health Service Act, the Appropriations Committee currently funds 36 separate health professions education programs. The Chairman's proposal would consolidate these 36 programs into 6 clusters streamlining authorizations and appropriations, and providing more flexibility to meet the purposes of these programs. His consolidation would reduce the federal bureaucracy needed to administer the programs.

More importantly, this proposal would include a national goal for the health professions education programs. In addition, it would provide a mechanism for evaluating how well the programs are doing in meeting this goal. By clarifying the purpose and perhaps even narrowing the current focus of the program, this proposal would better insure that program funds are making a difference.

Much of my own knowledge of the health professions education programs derives from the experiences my own state of Oregon has had with these programs. In August 1993 and April 1994, the Appropriations Subcommittee on Labor, Health and Human Services, and Education held field hearings in Oregon to examine our rural health care needs with particular focus on the shortage of health professionals. In both hearings, it became clear that the need to recruit AND retain health professionals in rural areas is an ever-present concern.

For example in Oregon, a large percentage of rural physicians are over 60 years old, and in a recent survey taken by the Oregon Office of Rural Health, 20 percent of these physicians indicated that they intend to retire during the next five years. This means that Oregon must recruit about 300 new physicians during the next five years! To put this into perspective, the Oregon Office of Rural Health is currently recruiting about 20 physicians a year, and Oregon has had a net increase of about 90 new physicians in rural Oregon since 1990.

Due to the leadership of the Oregon Health Sciences University, which includes the Schools of Medicine, Nursing, and Dentistry,we are beginning to make a difference by increasing the number of students graduating in primary care and choosing to practice in rural areas. One of the reasons for this is a program which is funded through Title VII of the Public Health Services Act and which I strongly support—the Area Health Education Centers Program.

By summer, every mile of the state of Oregon will be included in one of five Area Health Education Centers. Since 1990, Oregon AHECs have capitalized on a federal, state and local community partnership to establish community-based training programs including family practice residencies, frontier nursing programs, rural rotations by current medical students, continuing education programs using the distance-learning systems made possible by the Biomedical Information Communications Center at OHSU, and high school "Grow Your Own" programs.

I am pleased that the Chairman has included Area Health Education Centers as the primary cornerstone of the Community-based Training in Underserved Areas cluster. I have several comments about this aspect of your proposal which I hope you will consider as you develop it further. First, it is my hope that you will retain the name Area Health Education Centers as the name of the entity into which other relevant training programs are merged. AHECs are well-known and well-respected throughout the country and the Congress. Second, non-federal matching should be required of all of the programs merged with the AHEC program.

The AHEC program has always required matching funds from applicants in order to encourage a federal-state partnership. Third, AHEC programs require leadership by major academic health centers if they are to have a significant impact within their respective states. I urge that priority be given to applicants from academic health centers which include broad-based participation from each of the colleges involved in primary care educational programs. Finally, primary care residency edu-

cation will distribute more graduates into rural and underserved areas if the programs follow the AHEC concept of regionalization. Thus, I recommend that a preference in funding be written into the primary care authority for applicants that are either sponsored by or have close affiliations with AHEC programs.

Generally, I support the other consolidations and changes suggested by the Chairman. I would just mention two other issues. Under the current proposal, general dentistry programs are included in the sixth cluster—the Health Professions Workforce Development cluster. It is my hope that you will consider moving the General Dentistry Training program to the Primary Care and Preventive Medicine Training cluster. It seems to fit there more appropriately as 86 percent of general dentistry residents remain primary care providers. As a strong supporter of nursing training and education programs, I am pleased to see the changes you have made, especially with regard to giving the Secretary more flexibility in funding innovative projects. I would just like to mention my hope that the National Advisory Council on Nurse Education and Practice will remain a primary advisory body to the Secretary regarding nursing issues.

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Again, I appreciate the opportunity to testify before the Committee about these important issues and I look forward to working with the Chairman and other members of the Committee as this proposal moves forward.

The CHAIRMAN. Thank you very much, Chairman Hatfield. I think you have made some very important observations regarding the legislation. When you closed with the comment about the recommendation of a 10 percent reduction that this bill would project, do you think such legislation could withstand probably a recommended 20 percent reduction?

Senator HATFIELD. Madam Chairman, we are willing to face up to that responsibility if the budget resolution that is before us, or will be before us soon, states some of those caps or goals or whatever they may be.

Let me make this observation. On the first day of the session, I introduced what was called the Oregon Option, which we have demonstrated the State level. So much of our cost in overhead of any program—and we estimate that perhaps $500 billion is overhead with the block grants and other grants going to the States now—the single objective is compliance, that is to say, the accountability of those funds, is represented by accountability of compliance. There are 139,000 pages of Federal regulations. More and more of the dollar we appropriate, targeted for a Head Start child in a classroom, is being skimmed off by the cost of bureaucrats talking to bureaucrats, asking are you in compliance. The hours and hours of paperwork, the days and days of interviews, all reaching only one goal—compliance—in lieu of reaching a goal of success.

If we set goals together, as Federal and State partners, of what we want to achieve, lift the rules and regulations of compliance—now, that does not include civil rights or health and safety—but an awful lot of these other rules involve did you spend this in the first quarter, what percentage did you spend it at, and you fill out the forms, and you spend hours and hours—lift that and say we are going to make benchmark reviews of the success of your program, and if your program, through innovation and creativity, is making a greater success than the old way of doing it, all power to you.

I think we can reduce an awful lot of the cost of Government, we can get far more participation of people at the local levels, than merely bureaucrats talking to bureaucrats and filling out forms of compliance, not related at all to whether the programs are working or are successful or achieving goals.

I think we could make some remarkable reductions in the costs of Government. I would much rather address some of those methods of how we do business rather than just taking 10, 20 percent reductions off the caps and still wasting money, as we are wasting it, in my view, by peeling it off into bureaucratic control.

The CHAIRMAN. I could not agree with you more, and there are a fair number of heads nodding behind you, Senator Hatfield. Also, I would hope that as we work with this legislation further—and I appreciate the help of Senator Kennedy with this legislation—that we can take some of these things into consideration. We may really break new territory. I would like to do that; and I would also like to reinforce your comment about academic health centers and the importance of reaching out and their incorporation. I think that this has a tremendous impact on being able to work successfully together. The ripple effect has to be enormous.

Senator Kennedy.

Senator KENNEDY. Just very briefly, I want to thank our friend and colleague Senator Hatfield for taking the time on a rather extraordinary day to join with all of us here this morning. It is typical of his deep interest in the people whom he represents, not only in his State, but also throughout the country, in these health care matters, to come and speak, eloquently and knowledgeably, about a very, very important area of health policy. It is an area that he has spoken a great deal with me about. Even though we were not successful in dealing with some of the more comprehensive health issues, we tried to incorporate many of these suggestions into our health proposal last year. They are truths which, hopefully, we will not have to relearn, because of his continued involvement and attention to these issues.

These area health education centers have enormous impact on quality, particularly in attracting qualified, talented young people who would go out and serve in remote and rural areas if they knew they had the best in terms of support services, additional personnel, that their education and training would be upgraded so they would be able to get the kinds of skills they desired, and that they would be able to tap into the educational resources offered by these centers.

It has enormous importance in terms of how we are going to deal with getting good quality people in underserved areas, to provide the best medical care to people who deserve it. So I just want to express appreciation to you on that issue.

Finally, I would say that I join the chair in working and continuing to work to strike regulations. In the legislation last year, in Goals 2000, the Head Start program, Title I, we provided a very significant waiver of rules and regulations not only at the Federal level, but also at the State and local level, to make sure they are going to be able to do that. The Senator from Oregon had amendments on the floor of the Senate which we accepted in many of these areas.

Just as a final point, what we are talking about in this legislation are primary care functions, and when we are talking about savings resources, as the Senator would understand, what we are trying to do is enhance the role of the primary care function with good quality and good skills in terms of the allied professionals and in nursing, with the understanding that investment in those individuals can have a profound impact in terms of savings for our health care system further down the road.

So as we are looking at different items and at where we could have some belt-tightening, I think we also want to look in all health-related areas. In the area of health care professions, we are talking about primary care, we are talking about nurses, we are talking about the role of nurses, we are talking about increased responsibilities for those individuals in the primary care area. I do not think we want to shortchange these individuals.

We are talking about $400 million, and I know 10 percent is a big chunk of money over a period of time, but when we are looking at global issues of primary care and primary care functions, underserved areas, quality of health in underserved areas, we want to try to work with appropriations to tighten down in some of the other areas where I think it might have less of an impact in terms of the health care professions.

But we will work with the Senator, and we appreciate your very helpful testimony.

Senator HATFIELD. Thank you.

Madam Chairman, could I make one final observation?

The CHAIRMAN. Certainly.

Senator HATFIELD. As you take over your chairmanship, and as you have been the ranking member, and Senator Kennedy is now ranking member and has been chairman of this committee, I want to take this occasion to thank you both personally for being so open and so cooperative in working out suggestions and ideas from people who are not members of your committee. Also, I want to take this occasion to say that your staff on both sides have been the most open staff that I have experienced in my Senate career, in being helpful to individual staff like my own, and working with you on some of these ideas, like ED-FLEX, and math and science. So I want to thank the staff as well.

I am also proud to say that Secretary Riley was in Oregon just a few weeks ago to list Oregon as the first of six States to be used for experiments and demonstrations on the ED-FLEX bill——

Senator KENNEDY. He told me Massachusetts was.

Senator HATFIELD. He tells each one of us that. [Laughter.] But anyway, I want to thank both of you for having me.

The CHAIRMAN. Thank you, Senator Hatfield, for your dedication and your thoughtful observations. We very much appreciate your being here this morning.

Senator HATFIELD. Thank you, Madam Chairman.

The CHAIRMAN. I would also like to say that Congressman Louis Stokes, who is the ranking member of the House Committee on Appropriations, could not come this morning, but has a statement that he will submit for the record.

[The prepared statement of Mr. Stokes follows:]

PREPARED STATEMENT OF REPRESENTATIVE STOKES

Madam chair and members of the committee, I appreciate the opportunity to appear before you to discuss a very pressing national issue—"health professions education and training" and the related "crisis in minority health."

As a ranking member of the House Committee on Appropriations and as the chairman of the Congressional Black Caucus Health Braintrust, I would also like to take this opportunity to thank you and the other members of the committee for the cooperation and assistance you have afforded my advocacy to improve the health status of all Americans, and to help ensure minorities' participation in the health professions education and training programs. The members of this committee deserve commendation for their continuing commitment to meet the health and medical needs of the American people.

In fact, in 1990, I introduced in the House, and your colleague Senator Edward Kennedy introduced in the Senate, the Disadvantaged Minority Health Improvement Act. This legislation was designed to bring the health crisis and related concerns of the disadvantaged and ethnic and racial minority communities to the forefront of Federal health policy.

It is absolutely essential—that as we consider the reauthorization and the consolidation of the health professions programs—that we do not forget why there was a need to introduce the Disadvantaged Minority Health Improvement Act of 1990. It is also absolutely essential that we preserve and enhance programs that have worked.

Just a glimpse at the health disparity in minority and disadvantaged populations reveals and confirms the continued—need for and—enhancement of the programs authorized by the act. I would like to take just a moment to share with you some of the startling statistics associated with the matter that we are discussing here today. While our Nation invests billions of dollars in biomedical research each year, African Americans and other disadvantaged populations still have not reaped the full benefits of that investment.

—The infant mortality rate for African Americans is more than twice the rate for the general population.

—Both cancer incidence and mortality rates are higher for African Americans and Hispanics than for the general population.

—The life expectancy for white males is 8.2 years longer than for African American males.

—While accidents are the 5th leading cause of death in the total population, they are the 3rd leading cause for Native Americans, and 4th for Asian Americans.

—Minority children continue to be at greatest risk for vaccine-preventable infectious diseases.

—Disadvantaged elderly suffer a greater prevalence of chronic conditions.

Heart disease, stroke, aids, and diabetes are also more prevalent in minority and disadvantaged Americans.

With respect to health professions, while our Nation invests billions of dollars in health resources and services including health professions education and training, minority and disadvantaged populations still have not reaped the full benefits of that investment either.

Let's take just a moment to examine some of the problems and solutions. According to health professions manpower reports, America has too many physicians. Yet, there are over two thousand medical shortage areas in the United States. The fact of the matter is that minorities are severely underrepresented in all medical disciplines and specialties, and minority health care providers are those who have historically continued to practice in medical shortage areas.

According to the Association of Minority Health Professions Schools, minority health professionals comprise only 3.7 percent of all physicians, and 2.1 percent of all dentists in the Nation. This shortage is of concern because, if we are—to effectively address the crisis in minority health, and—to ensure access to quality health care for all Americans, the number of minorities in the health professions pipeline must increase. To accomplish this, scholarship and loan forgiveness programs would have to be enhanced and expanded. Additionally, the mentoring, recruitment, retention, and faculty development programs at health professions schools would have to be strengthened.

It must be recognized that minority health professionals have an intimate knowledge about the large segments of disadvantaged and minority communities that have been abandoned to suffer high mortality rates; shortened life expectancy; debilitating poverty, disability and disillusionment; and frustration and loss of hope. Minority health care professionals are in the trenches everyday, diagnosing, treat-

ing, serving, and counselling underserved populations across-the-country, in urban as well as in rural areas.

The enacted "Disadvantaged Minority Health Improvement Act of 1990"—which I originally introduced in the House—incorporated many of the solutions that I just outlined. That legislation is as relevant today as it was in 1990.

The act is currently up for reauthorization. In fact, we introduced the reauthorization legislation during this past Congress. While a number in the Congress tried to weaken the legislation, after extensive negotiations, the legislation passed the House. However, the Senate did not complete action on the legislation. as such, we must reintroduce the measure during this Congress.

As the Congress seeks to reauthorize the health professions education measure, it is extremely important that we do not forget why the programs contained in the "Disadvantaged Minority Health Improvement Act of 1990" were created. I can say in good conscience that these programs were not and are not just good intentions. They are programs that have a proven success record in improving the quality of life.

Because of the continuing health disparity, I am introducing the "Disadvantaged Minority Health Improvement Authorization Extension Act of 1995," in the House next week. The bill would simply provide for the extension of the programs that were enacted by the "Disadvantaged Minority Health Improvement Act of 1990." The measure includes the reauthorization of health professions loans, scholarships, and fellowships for minorities and the disadvantaged; the Department of Health and Human Service's Office of Minority Health; public housing health services; and centers of excellence. These are programs that have and continue to work. a simple reauthorization would allow these critical programs to continue.

The "Disadvantaged Minority Health Improvement Act of 1990" gave us new tools with which to improve health for all Americans. While more comprehensive legislation is warranted, I believe that it is best that we simply extend the authorization of these critical programs. A simple extension would allow these programs to continue improving the health status of the disadvantaged.

As the committee begins to draft health professions legislation, I would like to press upon the committee to remain mindful of the national benefit that has resulted from the investment in the programs I have outlined.

During deliberations on health care reform last year, it was emphasized by both Democrats and Republicans alike that any enacted health care reform legislation should emphasize improving primary care, increasing minority representation in the health professions, and improving access to health care for all Americans. These were laudable goals then, and they are laudable now.

Madam chair, this completes my testimony. Again, I thank you for having provided me the opportunity to appear before your committee, to discuss these very pressing national issues. I look forward to working with you and the members of the committee in drafting the "health professions education and training reauthorization" legislation.

Opening Statement of Senator Kassebaum

The Chairman. Before the Assistant Secretary for Health offers his observations, I would just like to make a brief opening statement to frame where we are with the health professions programs consolidation and reauthorization.

We will be considering modifications to the current health professions education and distribution programs. The examination of these programs will focus on three critical issues: 1) assuring that health manpower programs meet their historic purposes of addressing shortages and maldistribution of health professions, particularly in the areas of primary care and public health; 2) assuring that these programs are able to respond to new demands created by the reorganization of the medical marketplace; 3) improving the operation of these programs while being mindful of current budgetary realities.

Through Titles III, VII and VIII of the Public Health Service Act, the Federal Government currently provides over $400 million for 44 separate initiatives, and as Senator Kennedy said, in the light

of a $1.6 trillion budget projection, that does not seem like a lot. But what we are all engaged in is attempting to make sure that these are effectively and efficiently spent, and that they are willing to be open to new ways of delivery that will enable that to occur.

I have felt that the continued proliferation of separate programs has diluted their focus and ours. This is one of the things that has guided me in trying to improve and streamline current efforts. I have proposed consolidation of these initiatives, and under my proposal, future Federal support for health professionals programs would be targeted to primary and preventive care, minorities and the disadvantaged, community-based training in underserved areas, advanced degree nursing, and the National Health Service Corps. In recognition of the need for fiscal restraint, funding for these programs would be decreased by 10 percent by the end of the 4th year.

That is not necessarily a guideline as far as decreased spending, but what I do believe is important is trying to find, as I said, some different means of delivery system, and I think some of the suggestions made by Senator Hatfield were certainly worthy of consideration, and I am very pleased to be working cooperatively with Senator Kennedy and with the administration in trying to put forward the most constructive reauthorization bill.

I am pleased that the administration has put forward a similar proposal in many ways, which Assistant Secretary Lee will discuss this morning.

Senator Kennedy, do you have any further observations?

Opening Statement of Senator Kennedy

Senator KENNEDY. Thank you, Madam Chairman, and you have stated it absolutely accurately. We certainly look forward to working with you, and we are enormously appreciative of the chance for the input that we have been able to have.

I think we all want the best trained personnel. We understand the needs that our health care system requires, particularly in the areas of primary care and in underserved urban and rural areas, the distribution issues as well as the numbers. And we also take note of the extraordinary achievement and record of the efforts that have been made in the past in terms of economically disadvantaged Americans who want to participate in the health care system and be able to serve in many areas.

We obviously want that to be as a matter of choice, certainly, and not as a matter of destiny, and we want to build on programs that have been successful and to take note of those as well.

So we are very grateful, certainly to our panels here, which include some of our most thoughtful individuals on these issues, and I again want to underscore the importance of the nursing and nurse training programs for which there is special interest and support.

Thank you, Madam Chairman.

[The prepared statement of Senator Kennedy follows:]

PREPARTED STATEMENT OF SENATOR KENNEDY

Access to quality health care for all should be a central goal of the American health care system. But far too often, we fail to achieve that goal. Lack of access is an especially serious problem for people in underserved rural and urban areas.

Health insurance coverage for all is an essential part of making good health care widely available, but it is only a part of the solution. As we approach the next century, the success of health reform will also depend heavily on our ability to train more health professionals. No health care system can function effectively without an adequate supply of well-trained and capable providers.

The past two decades have seen impressive increases in the total-number of such professionals. The quality of training in American medicine is generally superb. Despite these successes, however, some types of health professionals—particularly those in primary care—remain in short supply, and the distribution of health manpower leaves many parts of the country under-served, or barely served at all. The task of maintaining an adequate supply of professionals from disadvantaged backgrounds, who typically have a strong interest in serving under-served communities, remains a major challenge. Millions of Americans, especially the very young and the elderly in underserved communities, have little or no access to primary and clinical preventive health care services.

The main purpose of our current health professions programs is to train more health professionals in occupations where the supply is too low, and to encourage students to locate and remain in underserved areas.

An important subsidiary goal is to assist disadvantaged students and institutions training these students, in order to expand the opportunities of those from disadvantaged backgrounds to enter the health professions and to help meet the needs of underserved areas. These are programs that work. As studies have shown again and again, health providers from disadvantaged backgrounds are far more likely to practice their professions in under-served communities. That needed result is enhanced by community-based training, which also encourages health professionals to stay on in underserved and shortage areas.

Training programs under Titles VII and VIII of the Public Health Service Act are the key mechanisms by which the Federal Government provides assistance to medical students and encourages the training of health professionals to meet national priorities. These programs are overdue for consolidation and better targeting, and I look forward to working with Senator Kassebaum and with the Clinton administration to achieve these goals responsibly and maintain adequate levels of resources. We must advance, rather than undercut, the central goal of these two titles of the Public Health Service Act—to train a health workforce that can meet the needs of the American people.

The witnesses here today will help us deal with these issues, and I look forward to their testimony.

The CHAIRMAN. I am very pleased to welcome once again before the committee the Assistant Secretary for Health, Dr. Phil Lee.

Secretary Lee.

STATEMENT OF HON. PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY DR. CIRO SUMAYA, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION; DR. FITZHUGH MULLAN, DIRECTOR, BUREAU OF HEALTH PROFESSIONS; AND DR. MARILYN GASTON, DIRECTOR, BUREAU OF PRIMARY HEALTH CARE

Dr. LEE. Madam Chairman, thank you very much, Senator Kennedy, Senator DeWine. It is a pleasure to be here this morning.

I am accompanied by Dr. Ciro Sumaya on my right, who is the Administrator of the Health Resources and Services Administration; on my immediate left, Dr. Fitzhugh Mullen, Director of the HRSA Bureau of Health Professions; and on my far left, Dr. Marilyn Gaston, who is Director of the Bureau of Primary Health Care.

In the testimony, which I will submit for the record, I will be describing the consolidation of the 37 categorical programs into five new clusters. I review the progress that has been made with these programs over the years. Senator Hatfield quite correctly said we cannot be satisfied with what we have accomplished, and we have to address the needs of 1995, not the needs of 1975.

But we have seen improvements in primary care curricula; we have seen funding of generalist training programs; we have seen increased opportunities for under-represented minorities; we have seen growth in mid-level practitioners, and we have seen the fostering of interdisciplinary training. All of those are I think important developments.

We do see some progress since the 1960's, when these programs actually began, in meeting the aggregate supply problems. However, we find that we have far too many specialists and not enough generalists, and Senator Hatfield very eloquently described the problems in Oregon, where a shortage of family practitioners who largely would practice in those rural areas has been one of the factors contributing to those shortages.

We have also seen how payments to hospitals by Medicare and other third-party payers for residents have contributed to the maldistribution. They have paid for whatever residency programs were developed, and as a result, hospitals developed training programs for specialists and subspecialists because in a sense, as with Willy Sutton, that is where the money was; they generated revenues. So we have had a serious maldistribution in residency training programs, and our public policies have contributed to that.

And of course, perhaps most important for physicians have been the payment policies of third party payers in the fee-for-service system, Medicare included, where procedure-based specialists, surgeons, radiologists, medical subspecialists, got paid disproportionately to the generalists. So that for evaluation and management, there was low pay relative to performing a procedure.

All of those have contributed to the problem. In nursing, we find most particularly now a shortage of advanced practice nurses. And in public health, we have I think serious shortages in areas like public health nursing, in epidemiology, biostatistics, and a number of other areas—environmental, maternal and child health.

We have, as Senator Hatfield so eloquently stated, shortages in rural areas, maldistribution. We also have inner city areas that are underserved because of the lack of generalists and the lack of systems of care to meet the needs in those areas.

And we clearly need multifaceted strategies to deal with these maldistribution problems. The National Health Service Corps has been one of those strategies, and it has made an important contribution. Loan forgiveness has been important, as have rural health initiatives, telemedicine. And again, Senator Hatfield mentioned distance learning. One of the most important things in the next 10 years will be the advances in telemedicine.

We also must continue to evolve in terms of reimbursement for both hospitals and physicians to better meet the needs in rural areas.

In terms of diversity, we need an increasingly diverse health professions work force to meet the needs of an increasingly diverse population. We have been reading recently in the New York Times about the problems in New York City's Health and Hospitals Corporation, where Spanish-speaking patients did not have providers who could speak their language, with consequences that proved to be, according to those articles, at least, very serious. It is very important that the physicians and nurses and other providers be culturally sensitive and be able to speak the language of those who are seeking care, and that has not always been possible.

We have also found recently market forces—and you mentioned this, Madam Chairman—that are having a profound impact on work force demands. They are hiring generalists, they are retraining physicians who have been trained in specialties as generalists. It would appear that in some of our rural areas and in some of the inner city areas, they are recruiting generalists, so that where we were beginning to have some effective solutions, we may be losing their practitioners into managed care plans.

So that as we look at that array of problems as you have, as Senator Kennedy has over many years, and as clearly, Senator Hatfield has and so eloquently outlined in his testimony, we see a new set of problems. And as you noted in your opening statement, we need to develop strategies to meet the needs in primary care for generalists, we need strategies to meet the needs for a public health work force. This is one of the more serious problems, and I know you will hear more detailed testimony about that later. We need to improve the operations of these programs, as you clearly stated. And we need to respond to the new demands. Again, I think your opening statement was just exactly what we would agree with.

Let me just briefly review the cluster proposals that we would be putting forward, and of course, we are looking forward to working with this committee.

First, the health professions work force development cluster would support a comprehensive system of financial assistance and related field service for students and provide for related research and data activities. Under a consolidated National Health Service Corps scholarship and loan repayment authority, financial assistance would continue to be available to students who agree to pro-

vide primary care services in an assigned health professional shortage area.

In addition, the proposed research and data collection authority would enable the Federal Government to work in partnership with States and others to both identify the gaps, to address the gaps in information about work force needs and resources, and to help assure data quality, completeness, compatibility and accuracy.

Second is the enhanced area health education centers cluster, which would continue the success of the AHEC, and I do not think I need to elaborate on this in light of both your comments and those by Senator Hatfield.

We would give States priority, but certainly the academic health centers would be an essential participant in these programs. The target would be to better distribute primary care professionals among underserved communities, particularly in this case, in the fields of dentistry and geriatrics.

Senator Hatfield suggested that perhaps the emphasis on dentistry should be in the primary care cluster, and we are certainly open to that suggestion.

Special consideration will be given to training networks designed to meet the unique needs of older Americans and of rural populations.

The third cluster is the minority disadvantaged health professions cluster, which provides for programs of institutional awards and scholarships for disadvantaged students. Under the institutional award activity, schools would be encouraged to develop programs and target recruitment and training activities at students early in the educational pipeline—and this is as early as the senior year in high school, for example. We have to get more disadvantaged students into universities so the pool for qualified applicants is significantly enhanced.

We believe this is the most effective means of achieving a sustainable, long-term increase in the number of minority students who pursue a health professions career. In making awards, preference would be given to projects which have a demonstrated commitment to retaining and graduating students from disadvantaged backgrounds and which involve more than one health professions discipline or training institution. And again, Madam Chairman, your emphasis on retention as well as recruitment is critical. It is not sufficient just to recruit.

Under a consolidated scholarship program, recipients and respective grant amounts would be determined by the schools. A service commitment by scholarship recipients would not be required in our proposal—now, that is an area where, again, we have some difference of view.

The next cluster is the primary care medicine and public health training cluster, which would include two components—one for family medicine, and the other for developing training networks for primary care and public health. The family medicine component would help establish and strengthen family medicine departments, medical student clerkships, and residency training programs.

These need to continue to be strengthened, and that is the reason for the emphasis on family medicine.

Primary care and public health training networks would integrate primary care training in family practice, general internal medicine, general pediatrics, and physician assistants, while increasing the linkage between primary care and public health training. Increasingly, I think we are going to see the need for public health practitioners and primary care physicians trained together, because we will have common goals with capitated health plans and public health to achieve health objectives for the population. So that kind of training is going to be increasingly important.

The nursing education and practice cluster would support activities in three general categories: 1) strengthening capacity for basic nurse education and practice; 2) nurse practitioners, nurse midwives, and other advanced practice nurses; and 3) increasing nursing work force diversity.

In my testimony also, Madam Chairman, I outline the areas where we have agreement with you on your proposals, and we can discuss that to the extent that you wish in the period for questioning. And certainly with respect to two areas—the extension of the programs for 4 years rather than 3 years—we would certainly be supportive. And finally, in the area of the Council on Graduate Medical Education, COGME, your proposal that would extend this through 1999, we would certainly support.

In summary, Madam Chairman, the administration looks forward to working with you and members of this committee to develop a reauthorization bill that would permit the Federal Government to strengthen its collaboration with State and local governments, educational institutions, professional groups, and community organizations to bring about changes in health work force training and practice to meet community needs.

We appreciate the opportunity to testify, and we will respond to any questions.

Thank you.

[The prepared statement of Dr. Lee follows:]

PREPARED STATEMENT OF DR. LEE

Madam Chairman and members of the committee, I am happy to appear before you this morning to discuss the Administration's proposals for reform and reauthorization of health professions and nurse education programs carried out under Titles III, VII, and VIII of the Public Health Service Act. I am accompanied by Dr. Ciro V. Sumaya, Administrator of the Health Resources and Services Administration (HRSA), Dr. Fitzhugh Mullan, Director of HRSA's Bureau of Health Profession, and Dr. Marilyn H. Gaston, Director of the Bureau of Primary Health Care.

In my remarks, I shall speak about the importance attached by the Administration to this clustering. Our proposal is to replace multiple existing categorical grant authorities with new cluster authorities addressing five broad areas of program need. This is part of our effort to reinvent government.

I have also been asked to summarize the status of the supply and distribution of each health profession and close with a few words about the Madam Chairman's draft bill.

IMPORTANCE OF CONSOLIDATION

The Administration is committed to establishing a sound legislative foundation for furthering leadership and strategic support in the field of health workforce development. Despite modest funding for more than 20 years, the health profession programs included in the Public Health Service Act have achieved remarkable success as a national resource.

—They have significantly enhanced the quality of primary care curriculum and fostered a growth in the interest of medical students in generalist practice.

—Funding of residency training opportunities in Family Medicine, General Internal Medicine, and General Pediatrics have increased our national supply of much need primary care physicians.

—They have opened opportunities for greater numbers of minorities to pursue and succeed in health professions careers and thereby expanded the access of millions of Americans to basic medical care.

—They have spurred an unprecedented growth in student enrollment among the mid-level professions of nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

—Through establishment of interdisciplinary training centers in geriatrics, we have improved the quality of health care received by older Americans and the training given to their health care professionals.

Secretary Shalala and I are committed to assuring that the Administration's reform proposal for health professions programs build upon these successes.

Current health care financing systems have created incentives for a physician work force trained in high-cost, high-tech, episodic methods of care. The workforce also trains and utilizes too few nurse practitioners and other non-physician health professionals.

The rapidly growing competitive health care market is also changing the type of health care professional needed, as well as increasing the demand for primary care practitioners. Graduates who have had training in community-based settings and cost-effective approaches to practice are lacking. There continue to be few program which provide interdisciplinary training.

Thus, in its present configuration, the provider workforce and associated training program are not well matched to national needs. Bringing about the changes needed will require targeting scarce resources to create positive incentives for reform.

HISTORICAL CONTEXT OF PROPOSALS

Between the early 1970's and 1992, there was steady growth in small categorical programs which addressed special health care needs. Although each met a perceived need, the abundance of narrowly-focused health professions authorities today limit the Government's flexibility to prioritize limited funding and respond effectively to emerging health workforce challenges. We believe the current categorical grant system has come to place unreasonable administrative burdens and costs on grantees and Federal administrators.

The Title VII and VIII health professions programs were most recently reauthorized in 1992 by a law that placed needed emphasis on meeting needs for health workers in primary care and in medically underserved areas. Certain scholarship and low-cost loan programs were made conditional upon service in primary care. For many great programs, the 1992 law established a general preference for applicants who demonstrated success in placing graduates in medically underserved communities.

The Administration's reform proposals will target our limited resources to high-priority needs which cannot be met by the private sector or State and local governments acting alone. The cluster proposals establish a framework within which the Federal Government can work in partnership with State and local governments to assist health professions schools, professional organizations, foundations, and other non-Federal entities to develop comprehensive approaches to meeting health workforce needs. Requirements for consistency with related State and Federal plans and for linkages among health care and educational entities would promote multidisciplinary and interdisciplinary approaches and encourage community involvement in training programs.

—Each cluster authority would replace multiple categorical authorities and special eligibility and project retirements with a comprehensive, flexible, and effective Federal authority. Clear goals and performance measures would be established and monitored. Grantees would be freed to target limited resources to areas of greatest need. Administration would be simplified, and a more integrated approach to program development adopted.

—Each cluster authority would have as its purpose (1) achieving specific outcomes in health professions workforce development; (2) streamlining the administration of program initiatives; and (3) maintaining appropriate training activities. The program restructuring which address cross-cutting issues relating to training cites, community-based training, and quality improvement would be phased in, permitting an orderly transition of programs.

—Under each authority, the Department of Health and Human Services, in collaboration with grantees, would develop goals and performance measures tied to program objectives; develop individualized performance agreements with grantees;

and support a data standards-setting process to promote development of uniform performance measures. Award of funds based on ability to meet performance outcomes would help focus scarce Federal resources on activities that have a demonstrable impact on the availability of health workers to meet a national and state need.

—Applications for funding would be accepted from one or more of the following: health professions schools, academic health centers, State or local governments, or other appropriate public or private nonprofit entities. Requirements for consistency with related State and Federal plans and for linkages among health care and educational entities would emphasize multidisciplinary and interdisciplinary approaches and encourage community involvement in training programs.

—Funds could be used for costs of planning, developing, or operating demonstration training programs, faculty development, curriculum improvement, trainee support, technical assistance, workforce analysis, or other activities that will produce desired outcomes. The flexibility would maximize the "leveraging potential" of Federal funds, and grantees would have broad discretion in the use of funds.

—Preference in the award of grants would be given to projects that meet specified standards for output of graduates who serve medically underserved communities or populations. This preference, already applied to certain Title VII and VIII programs, would reflect the Government's continuing commitment to help meet the needs of these communities.

—The Secretary would be authorized to reserve up to 10 percent of funds from each cluster to reward recipients that make improved progress toward goals.

—Non-Federal matching of Federal funds could be required as appropriate to assure institutional commitment to projects and to increase total funding available for the activity. Matching retirements encourage local communities and educational institutions to make resource commitments to the activity and enhance the prospects for continued operation of a project following phase-out of Federal aid for that project.

—Existing grantees under programs in effect prior to the enactment of the new authority could continue to receive funds through the end of the approved project period. This provision would prevent disruption of ongoing programs and will allow time for institutions to develop individual or collaborative applications for funds under the new authority.

In contrast to current law, the Administration's proposal would reduce the total number of awards and provide administrative savings through a reduction in rehired applications and reports. Program consolidation responds to concerns about the need to reduce the overall number of Title VII programs.

CHARACTERISTICS OF SPECIFIC CLUSTERS

The five specific reform clusters proposed by the Administration are:
—Health Professions Workforce Development
—Enhanced Area Health Education Centers
—Minority/Disadvantaged Health Professions
—Primary Care Medicine and Public Health Training
—Nursing Education/Practice

The Health Professions Workforce Development Cluster would support a comprehensive system of financial assistance and related field service for students and provide for related research and data activities. Under a consolidated NHSC Scholarship and Loan Repayment authority, financial assistance would continue to be available to students who agree to provide primary care services in on assigned health professional shortage area.

In addition, the proposed health professions research and data collection authority will enable the Federal Government to work in partnership with States and others to address gaps in information about health workforce needs, and resources, and help assure data quality, completeness, compatibility, and accuracy.

The Enhanced Area Health Education Centers Cluster would continue the success of the AHEC program by working with States, academic health centers, community organizations, and employers to expand the operation of interdisciplinary outcome-oriented training networks. In a shift of emphasis from the past, we will give States priority in receipt of awards and encourage them to better target gaps in the distribution of primary care professionals, particularly in the fields of dentistry and geriatrics, among underserved communities. Special consideration will be given to establishment of training networks designed to meet the unique health needs of older Americans and of rural populations.

The Minority/Disadvantaged Health Professions Cluster provides for programs of institutional awards and scholarships for disadvantaged students. Under the insti-

tutional award activity, schools would be encouraged to develop programs and target recruitment and training activities at students early in the educational pipeline. We believe this is the most effective means of achieving a sustainable, longterm increase in the numbers of minority students who pursue a health professions career. In making awards, preference would be given to projects which have a demonstrated commitment to retaining and graduating students from disadvantaged backgrounds and which involve more than one health discipline and/or training institution.

Under a consolidated scholarship program, the Secretary would make grants to schools of medicine, osteopathic medicine, dentistry, public health, and baccalaureate or graduate-level nursing, and to physician assistant training programs. Scholarship recipients and respective grant amounts would be determined by the schools. A service commitment by scholarship recipients would not be rehired in part to acknowledge the underrepresentation of students from disadvantaged backgrounds across the range of medical specialties and health professions.

The Primary Care Medicine ad Public Health Training Cluster would include two components, one for family medicine residency capacity building, and the other for development of training networks for primary care and public health. The family medicine component would help establish and strengthen family medicine departments, medical student clerkships, and residency training programs.

Primary care and public health training networks would integrate primary care training (family practice, general internal medicine, general pediatrics, and physician assistants) while increasing the linkage between primary care and public health training. Interdisciplinary training is essential to achieving national, regional and local goals in primary care and public health training.

The Nursing Education/Practice Cluster would support activities in three general categories: (1) Strengthening capacity for basic nurse education and practice; (2) nurse practitioners, nurse midwives, and other advanced practice nurses; and (3) increasing nursing workforce diversity.

STATUS REPORT: SUPPLY AND DISTRIBUTION OF THE HEALTH PROFESSIONS

Physicians: Most experts who have looked at the Nation's supply of physicians have concluded that, in general, while the nation has an adequate, or more than adequate supply of physicians, there are too many specialist physicians, and too few generalists. The present situation is the result of both explicit Federal and State, and private sector policies to increase physician supply and payment policies that have provided strong economic incentives for physicians to enter surgical specialties, medical subspecialties, and radiology.

Beginning in 1963, the Federal Government responded to perceived shortages of physicians through grants and loans to medical schools for expansion of facilities and funds for student financial aid. By the late 1960's direct per capita payments for expansion of medical school class size were made. The nation moved from a physician supply of about 300,000 active physicians (150 per 100,000 population), to 600,000 (240 per 100,000).

In the 1960's, Congress declared that there was a shortage of physicians in the United States. This declaration resulted in changes in immigration policies that added substantially to the physician pool by encouraging an influx of graduates of international medical schools (IMGs). One-fifth of all practitioners in the United States are now IMGs. These numbers have increased rapidly during the past 20 years. In 1994, there were about 1,500 international medical school graduates in residency training programs in the United States, versus 18,500 United States graduates.

Another Federal policy initiated in the 1960's and 1970's which affected physician supply was that under Medicare, direct and indirect educational payments were structured as an add-on to hospital payments. This provides an incentive to expand the number of residency training programs and positions, because of the favorable payment policies.

In 1961, physicians in the United States were evenly divided between specialist and generalists. Today, more than two-thirds of physicians, are practicing as specialists. These trends were in part the result of the rapid advances in biomedical research and technology, the rapidly growing body of knowledge that had to be understood by physicians, and payment policies which favored specialists. Although interest in primary care among medical school graduates is rising slowly, it remains far below levels required by an health care delivery system that is efficient, cost effective and accessible.

Nursing: Nursing constitutes the largest segment of those employed in health care. In 1992 our health care system employed 1.8 million registered nurses (RN), 550,000 licensed practical nurses/vocational nurses (LPN/VN); and 1 million assistive

nursing personnel. Despite growth in the nursing workforce during the past decade, we know the need for trained community and advanced practice nurses to work in primary care, clinical nurse specialties, and in a variety of sites, including schools, long term care facilities, and other non-hospital settings is increasing sharply. Such demand signals new employment opportunities for many Americans if we can support the faculty and educational infrastructure to meet the needs of new students.

Public Health: While there is an oversupply of physicians and nurses for personal health care, that is not the case in public health. The goal of public health is to protect and promote the health of all Americans and to prevent disease. The responsibilities of public health professionals include: preventing epidemics and the spread of disease; providing protection against environmental hazards; preventing injuries; promoting and encouraging healthy behaviors; responding to disasters and assisting communities in recovery; and assuring the quality and accessibility of health services (see attachment). Although data are limited, reports to Congress on the Status of Health Personnel indicate consensus that there are shortages of public health personnel such as public health physicians and nurses, environmental health professionals, and personnel trained in epidemiology, biostatistics, and laboratory analysis.

GEOGRAPHIC MALDISTRIBUTION

In spite of the huge increase in physician supply in the past thirty years, serious shortages remain in many rural and inner city areas. To meet the direct needs of isolated rural regions, and poor inner-city areas, a multi-faceted approach has emerged which includes State loan forgiveness, rural health initiatives, reimbursement by Medicare, telemedicine, and the National Health Service Corps (NHSC). The NHSC WAS created in the early 1970's to provide health care practitioners for designated health professions shortage areas. Through the NHSC scholarship program the Government pays the full cost of a student's professional education and, in return, the student agrees to serve for several years in a region with critical shortages of health care personnel. In 1994, approximately 1,900 NHSC physicians, nurse practitioners, nurse midwives, and dentists represented the only available source of basic health care for 3.8 million Americans and their families. Corps members served in communities ranging from Tribune, KS to the Roxbury community in Boston and Bridgeport, CT. About 20,000 health care professionals have served in designated shortage areas since 1970. Some 14,000 haven received scholarships; others received low repayments; some were volunteers. Despite the notable contributions of the Corps, there continue to be thousands of communities which meet the definition of health profession shortage areas in which millions of individuals live.

WORKFORCE DIVERSITY: MULTIRACIAL-MULTICULTURAL

Minorities continue to be seriously underrepresented in the health care workforce. While comprising 22 percent of the population, members of disadvantaged minority groups make up only 7 percent of physicians, 10 percent of medical students, 8 percent of nurses and physician assistants, 5 percent of dentists and 3 percent of allied health personnel. We must work to remedy this lack of minority professionals if we are to expand the availability off health care services to disadvantaged populations and do so in a culturally appropriate manner. The effective practice of medicine must recognize the vast diversity of cultural beliefs that affect health behaviors. Our educational system must strive to recruit and educate health care personnel who can bent respond to those needs.

COMMENTS ON THE MADAM CHAIRMAN'S DRAFT BILL

Madam Chairman, we were pleased to have an opportunity to review an early version of your bill and encouraged by your approach to the reform of these authorities. The draft bill, like the Administration's proposal, seeks to better focus limited Federal resources by substantially reducing the number of categorical health professions programs that comprise Titles VII and VIII. Your draft legislation would replace these programs with a smaller number of comprehensive, efficient and flexible authorities.

Although there are areas where the proposal departs from the Administration's proposal, this morning I would prefer to use my remaining time to comment on those areas of agreement. In the coming weeks we look forward to working closely with you and the other Members of the Committee in a truly collaborative spirit. It is clear we share the same objectives of using the reauthorization process to sharpen, refine and build upon the success of these programs.

Like the Administration's proposal, the draft bill's proposal for the Disadvantaged Health Professions Training authority provides the Secretary a broad and flexible authority to guide the allocation of funding. We agree that preference should be given to projects that involve more than one health profession's discipline or training institution and have an above average record of retention and graduation of individuals. We are pleased to note that existing grantees would be protected during their current grant periods.

Similarly, the Primary Care and Preventive Medicine Training, Health Professions Workforce Development, Community-Based Training in Underserved Areas, and Nursing Workforce Development place greater reliance upon outcomes, encourage collaboration among health and educational institutions, and simplify program Administration.

We like your proposal to extend the authorization period to four years rather than three years as suggested in our proposal.

In summary, Madam Chairman, we look forward to working with you to develop a reauthorization bill that will enable the Federal Government to strengthen its collaboration with state and local governments, educational institutions, professional groups, and community organizations to bring about needed changes in health workforce training and practice. Although we may differ on specific approaches to achieving health professions reform, we agree about the importance of continued Federal leadership and the need to make better use of what limited Federal support is available.

I would be happy to answer any questions you may have.

ATTACHMENT

PUBLIC HEALTH IN AMERICA

Vision:

Healthy People in Healthy Communities

Mission:

Promote Physical and Mental Health and Prevent Disease, Injury, and Disability

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

Source: Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee

Membership:
American Public Health Association
Association of State and Territorial Health Officials
National Association of County and City Health Officials
Institute of Medicine, National Academy of Sciences
Association of Schools of Public Health
Public Health Foundation
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
U.S. Public Health Service
Centers for Disease Control and Prevention
Health Resources and Services Administration
Office of the Assistant Secretary for Health
Substance Abuse and Mental Health Services Administration
Agency for Health Care Policy and Research
Indian Health Service
Food and Drug Administration

Fall 1994

The CHAIRMAN. Thank you very much, Dr. Lee. I appreciate your thoughtful observations.

In talking about where there was an undersupply, you mentioned public health nurses, among others. It seems to me that often—and I am sure there will be testimony coming later regarding the nursing programs—but from just a casual observation, it would seem to me that in some areas, we have an oversupply of nurses, and in others an undersupply perhaps largely because career options are not given adequate attention. I am thinking really of recruitment for public health nursing. Has this shown to be a problem?

Dr. LEE. I would say absolutely there are some areas where there is an oversupply. In some areas of nursing, for example, in the hospital-based nurse training programs, we have an ample supply of basically hospital nurses in most areas except for some rural areas; but in some other areas, like primary care nursing, in some geographic areas, there are nurse shortages, and in some specialty fields like midwifery or primary care nursing or clinical nurse specialties, I think there are areas where advanced practice nursing, baccalaureate degree nurses with advanced clinical training, where there are definitely shortages.

So it does vary by geographic area, and it varies by the level of training of the nurses.

The CHAIRMAN. But I am also asking whether we give enough attention to encouraging nurses to look at public health nursing.

Dr. LEE. I do not think we do that, and I think we have to take some responsibility in that area. It is interesting—we now have an exhibit coming into my office of the Nurse Cadet Corps in the Second World War. The commitment at that time of the Public Health Service and the Federal Government to meet a particular need showed how dramatically successful a targeted program can be. And I agree with you that we need to give greater priority from our standpoint in the Department and in the Public Health Service to public health nursing.

The CHAIRMAN. I just happen to feel it is a very important component, and I am pleased that you recognize and realize that perhaps it needs a little advertising.

Senator Hatfield mentioned moving dentistry to preventive and primary care. I have it under the work force development. But let me just ask, is dentistry in over- or under-supply at this point?

Dr. LEE. Dentistry is quite different than, say, medicine, because there is much less insurance; it is much more fee-for-service. But there are very significant unmet dental needs, although we have made very, very significant progress with fluoridation, for example. It is one of the most effective preventive programs that we have ever had in reducing dental caries. But there are still significant unmet needs, and I believe we need more dentists in areas like children's dentistry and in some areas of restorative dentistry, we need more in geriatrics in general dentistry, we need more in rural areas. There are significant unmet dental needs in rural areas, and the market at the present time has not been sufficient to respond to those needs; in other words, the market forces have not brought general dentists in the main into rural areas. So that there are some targeted shortages.

The CHAIRMAN. But is there anything to indicate that dentists, any more than anyone else, are likely to go to underserved areas?

Dr. LEE. No, I do not think so. I do not think we have any evidence—and maybe I could be corrected—but the factors that affect a practitioner going to a rural area—obviously, there are income opportunities, professional opportunities, schools for their children, and other factors which affect whether somebody moves and then stays in a rural area—or in an inner city area, there are other things that affect their willingness to practice in those areas. And I do not think dentists are any more willing than others to overcome those obstacles.

The CHAIRMAN. Thank you. My time is up.

Senator Kennedy.

Senator KENNEDY. Thank you very much.

I particularly appreciate the focus on children and children's dentistry. On fluoridation, going back a long period of time, we had a $10 million voluntary program, and you would have thought we had a nuclear meltdown over on the floor of the U.S. Senate among some of my environmentalist friends, about how we are contaminating and poisoning the water. In Charlestown, MA, the average 10-year-old has 10 cavities; yet they do not have them out in Brookline, and they do not have them in Newton, because they have fluoridated water in other parts of the State. So we still have a long way to go.

I wonder if you could just briefly comment about the importance of investing in the primary care functions and the impact that that has in terms of the total cost of our health care system. Isn't this an important investment in terms of overall health care costs in terms of improving access to quality health care and preventive services through an enhanced primary care function, and doesn't that have a very powerful impact?

Dr. LEE. The well-trained primary care physician or nurse practitioner can have a very significant impact first of all on access to care. Without well-trained primary care clinicians, your entry point becomes any of 50 different subspecialties, and that does not result in good coordination of care.

The primary care generalist, who first of all must make the right diagnosis—is this person seriously ill, or is it a common problem, and what is the best approach to treatment—and then the continuing coordination of the care and, in many cases, providing that care directly. Those two functions if performed well can significantly lower the rate of increase in the cost of care. Studies by Al Tarloff in Boston and his group show that generalists treating people even with chronic conditions, the outcomes are equivalent, and the costs are significantly less.

I think we have significant evidence that a well-trained primary care work force—and I emphasize the need for good training—would be very important to both access, quality, and cost.

Senator KENNEDY. And I think it helps to underline the importance of making sure that we do not short-change these very important programs.

Second, we can assume that the emphasis you are giving in terms of the primary care function is also across-the-board in terms

of the administration's position on reimbursement programs, Medicare, and other areas?

Dr. LEE. Yes. We are, of course, following Congress' lead on physician payment in the Medicare program, but that is very consistent with the approaches we are taking—greater emphasis on payment for evaluation and management, and decreased emphasis on payment for radiology and other services.

Senator KENNEDY. This is important, because for years, we were trying to do one thing here, and the other committee was doing the other part, and there was a continued mish-mash. So I think having a consolidated approach will have long-term benefits.

Just briefly, Senator Hatfield talked about reducing the administrative costs. Of course, all of us are interested in reducing the administrative costs. But what is your own estimate, or have you made an estimate, in the consolidation of these program about what can realistically be saved? I do not want to see cutbacks in programs on the premise that "X" amount can be squeezed out of these programs, and therefore we can just go ahead and cut out millions of dollars, and not think we are going to have an impact on the quality of those programs. We are interested in as accurate information as we can have on that.

Dr. LEE. Let me just show you an example. In the Bureau of Primary Care, this is the previous proposal that was submitted. Already, they have boiled it down to this. Now, this is the kind of change—we will see reductions in the need for people in the Federal work force. As a result, we will have money savings and FTE savings over the next 5 years—I think it is about $15 million that we estimate savings, just in terms of administrative savings on consolidation. And then, at the level of the recipient, when you have to fill out an application like this, instead of one of these, you are going to see significant savings at the receiving end as well.

Improved efficiency and improved outcomes will, I think, also be results because these will be results-oriented, they will be outcome-oriented, just as Senator Kassebaum has proposed in her proposals. And I think we will see more effectiveness, which is where the big savings will really come.

Senator KENNEDY. Finally, I pose a broader question more than a specific one—we provide a good deal of help and assistance at the Federal level in terms of the medical education programs, unlike what we do in terms of law school, for example, and we have a range of ways which have been outlined here in the course of this legislation and, as we know, in Medicare support and other support for medical education programs.

Do you want to comment about why that is necessary, why there has to be Federal involvement? In this committee, we hear a good deal about why we need to have support in terms of the humanities, why we need it for the arts, why we need it for public broadcasting. Why do we need it in terms of the training of health care personnel? That would be number one. And second, what do we say to the optometrists, the podiatrists, and the chiropractors in terms of the reduction in support of their functions?

Dr. LEE. First of all, with respect to health, public health is a public good. We cannot achieve the health of the public without a common set of policies, and that actually means at the community

level, at the State level, or at the Federal level, whether it is support of biomedical research, whether it is the public health protection programs of, let us say, the Food and Drug Administration, whether it is work force policies, where you have shortages that are not met by the market, we fill those gaps. Where there is a market failure, then we have collective action to meet the need. And certainly primary care is one of those areas where we have seen a market failure. Research is another one. We have NIH because the private sector will not provide the funds for the support of basic research; yet our pharmaceutical industry and our health care delivery are very dependent on that kind of research support.

So that there is a public good that is the basic rationale, and where there is market failure, and where that cannot be met by a State action, then there needs to be Federal action. And there are really four areas where we do that—one is research, one is broad public health areas; FDA would be included in those; support and services to vulnerable populations that are not met at the State level, and Medicaid is an example of that, as is the Indian Health Service; and then there is the development of infrastructure, where we see NIH, CDC, and the development of information systems, the information superhighway. Those are appropriate Federal functions in partnerships with States and the private sector to meet a need that none of those can meet alone.

With respect to chiropractic, optometry, and other health professions, there are areas where there is a local market, and there are areas where there is a national market. Where there is a national market, I think there is a Federal role. Primary care medicine is such a national market. Where the market is principally local or within a State, then I think you would have to justify in those areas why you would have a Federal role to subsidize the development of those special health professions.

So that is the way I would look at those and look at other health professions.

Senator KENNEDY. Very good. My time is up. Thank you very much. It is nice to welcome you back, Dr. Lee.

Dr. LEE. Thank you. It is a pleasure to be here.

The CHAIRMAN. Senator DeWine.

Senator DEWINE. Good morning, Mr. Secretary. Just a general question. We have talked this morning about underserved populations, underserved areas, the need for having more minorities as care providers, everything from doctors, nurses, etc. I am wondering if you could give me some historical perspective of where we are in this country in those three areas—say, today versus 5 years ago, 10 years ago, 20 years ago? It is a real general question, and all I expect is a general answer.

Dr. LEE. Well, if we go back to when I served in this job the first time in 1965, and when Senator Kennedy——

Senator DEWINE. That is called historical perspective.

Dr. Lee [continuing]. That is historical perspective. But our health manpower policies in those days were designed to meet very serious shortages that were identified. Everybody agreed we had a very serious shortage of physicians. The policies that were developed in concert with the American Medical Association, the Association of American Medical Colleges, the nurses, said that we

needed to strengthen and expand enrollment in existing schools and develop new schools. There were States like West Virginia that did not have a medical school. There were States like New Mexico that did not have a medical school, had serious shortages; or areas of the country—in my own State of California, San Diego did not have a medical school. Creating new medical schools in those areas helped to solve their physician, and in many cases, other manpower shortage problems.

By the mid-seventies, it was very clear that we no longer had an aggregate shortage. In fact, some people even suggested we had already overshot the mark.

Two reasons affected that. One was the rapidity with which the U.S. institutions responded to these incentives—capitation grants for enrollment and capital funding to expand the facilities, student financial aid. Those were very effective polices in meeting those identified needs. We then began to see—and with rapid immigration, because Congress said there was a health manpower shortage. Immigration policies were changed; foreign medical graduates could enter, and they entered very rapidly. Now, about 20 percent of our physician work force are graduates of foreign medical schools.

I think we have overshot the mark a bit, so we now need to deal with—and as our reimbursement and Medicare and Medicaid—to deal with underserved populations. And Medicare, although expensive, has been tremendously successful not only in access to care and quality of care, but improvement in the health of the elderly has been more rapid in the United States than in many other countries since Medicare was enacted.

So we designed policies to meet particular needs, and they met those needs. We now have a different set of problems. We have cost problems that we did not have in the sixties. We have physician and other work force issues now—oversupply of specialties, undersupply of generalists.

In the mid-1960's, after the Civil Rights Act, medical schools, nursing schools, dental schools, pharmacy schools and others dramatically changed their admission policies. Women began to come into medical schools; now about half the entrants are women. We have seen significant increases in minorities. But because of their financial disadvantage, and in some cases because of earlier educational disadvantage in high school and in college, they have not had the same opportunity as more economically advantaged students or educationally advantaged students.

So those problems, although we are moving toward correction, we still have a way to go.

In terms of underserved areas, rural areas, those needs persist. The policies have not been as effective in addressing those needs. In the inner city areas—and you will hear later from Reed Tuckson, who is providing great leadership in Los Angeles to organize a medical school and a teaching hospital to meet the needs of an inner city area.

So those are I think the new problems. I think we have found that we can, working together, solve the problems if we identify the right problems and targeted our solutions.

Senator DEWINE. Thank you very much.

Thank you, Madam Chair.

The CHAIRMAN. Well, that was an interesting survey of past needs and how they have changed. Thank you very much, Dr. Lee. It is a pleasure to have you here this morning.

Dr. LEE. Thank you. I hope that when I take this job in 25 years, we will not still be addressing the same problems. [Laughter.]

The CHAIRMAN. Well, we are working on it; I am sure that will be the case.

Thank you very much, Secretary Lee.

The CHAIRMAN. We welcome the next panel. It is a pleasure to welcome first Dr. Gary Filerman, associate director of Federal programs at The Pew Health Professions Commission; second, Dr. Reed Tuckson, president of Charles R. Drew Medical College, University of Medicine and Science; and Dr. David Kindig, professor of preventive medicine and director of the Wisconsin Network for Health Policy Research, University of Wisconsin-Madison Medical School.

We welcome all three of you and your great insights to this issue. All three of you have contributed a great deal in the past to trying to understand the questions that face us in health and the health professions.

Dr. Filerman.

STATEMENTS OF GARY L. FILERMAN, ASSOCIATE DIRECTOR, PEW HEALTH PROFESSIONS COMMISSION; DR. REED V. TUCKSON, PRESIDENT, CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE; AND DR. DAVID A. KINDIG, PROFESSOR OF PREVENTIVE MEDICINE AND DIRECTOR, WISCONSIN NETWORK FOR HEALTH POLICY RESEARCH, UNIVERSITY OF WISCONSIN-MADISON MEDICAL SCHOOL

Dr. FILERMAN. Thank you, Senator Kassebaum. It is a pleasure to be here and say hello to the members of the committee.

I am Gary Filerman, associate director of the Pew Health Professions Commission, which is an entity of the Pew Charitable Trusts, established about 6 years ago to move through the private sector to accomplish exactly the same objectives which you are addressing in the reauthorization discussions this morning.

I am going to make some general observations in the interest of time and then some specific comments about just a couple of the health professions to not duplicate the areas that will be discussed by Drs. Kindig and Tuckson and then would appreciate having my testimony and supporting documents entered in the record.

The CHAIRMAN. Without objection, they will be included.

Dr. FILERMAN. I would like to begin by adding to the dialogue a few minutes ago about the rationale for the Federal role in this arena, because this is a time when it needs to be clarified, restated and reemphasized. The Pew Commission, which is very much a private sector enterprise, is very much convinced that there is a very appropriate and unique Federal role in the area which we discuss today.

The Federal Government is the biggest buyer of health services in the United States, and one could look at the educational establishment, if you will, as the biggest vendor. And as the biggest buyer, the Federal Government has a prudent buyer interest in as-

suring for, if no other reason than effective cost containment, that the right competencies are in the right place at the right time. There is no way that cost containment strategies are going to be achieved unless that work force is in place.

The second reason—again, as has been alluded to somewhat earlier—is that the shape of the current educational enterprise is in no small part the result of the Federal programs of the past and those which we are examining today; and most particularly, of course, the Medicaid program, which recognizes very directly the interdependence of the work force and the Government's need to be a buyer and supporter of the work force development needed to provide the services.

Now, as to the clustering strategy, again, that is an area with which I think we can identify strongly. We think it is going to make a major contribution to the cost-effectiveness of the Federal programs. Indeed, I think it could be stated that there is a point in the development of the small categorical programs where they in fact impose rigidities that are not cost-effective.

On the other hand, small is not necessarily bad, and some of the small programs have been very effective, well-leveraged, and creatively managed.

I would like to make six sort of generic suggestions relative to the overall strategies that are common to the two bills. First, we think that the bills should recognize more explicitly the responsibility of the Secretary to provide leadership in guiding health professions education toward rapid and flexible response to the health service market. The leadership role I think is often underestimated; it is not very expensive, but it is an important charge. The role now is too diffuse and underpowered. I think the potential has been very well-demonstrated by the Nursing Council, by COGME, and some other initiatives, but they are not well-funded, they are not well-staffed, and I think there is a better way to do it.

Second, we believe that all of the authorizations should be used to enhance essential competencies for a population-based and prevention-centered system. There are many health professionals coming out today who do not have the competencies which are going to make it possible for them to contribute to and function effectively in the new health care system, and that has to be corrected, and those can be identified. Essentially, in a nutshell, it is the shift from a sickness system to a health system.

Third is that we think that all of the authority should be used to encourage a much more effective partnership between the practice community or the marketplace and education. Schools have to change the way they work with the organizations in which most people are going to practice and make them much more comprehensive.

Fourth, we think that that partnership between all of the sectors involved should be extended to the Federal level through the establishment of a national health professions development board, which should be charged with monitoring the need, evaluating programs, and advising the broad community, including this committee, on the progress of the effort to reengineer the work force. In other words, we need a national focal point for these discussions on a continuing basis.

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We have already heard this morning a number of comments about evaluation, but where does that evaluation go, and who gives advice in response to it?

Fifth, expand the bill's emphasis on evaluation to support research into outcomes or the value added of occupations and task groupings and specialties. It is time to advance outcome science into work force evaluation. It is a large gap.

And sixth, improve the quality of work force information, which is the only way you are going to empower the marketplace. The weakness of the current data contributes to poor career choices, poor educational planning by the State schools and programs. Much more can be done with it.

Let me just comment briefly on a couple of the specific professions, starting with a comment about nursing. We strongly agree with the emphasis on advanced practice nursing, but we believe it is time to address the need to shift a lot of the support to the baccalaureate level, because the modern science and modern practice requires a higher educational level for the nurses that are going to go out into the communities and play key roles.

In the public health section, the issue there is the shortage of people, and I would suggest that that numbers gap is only going to be addressed by a dramatic expansion of the size of the public health education component, but at the baccalaureate level. Let the graduate schools do what they do best—the research, training of the teachers, and so on—but let us develop a set of programs that are going to meet the need for massive numbers of health workers to work in the counties, in the cities and the States across this country—a need which we currently have absolutely no strategy to deal with, including those in the bills.

Finally, Senator, it strikes me that the way the clusters are approached, focusing primary care on the physician, basically, and putting nursing in another section really does not deal effectively with the integral relationship of the professions in meeting the primary care need. The primary care need is the primary care need, and I think those clusters ought to bring together advanced practice nursing for primary care, the physician's role in primary care, and perhaps, as has been suggested earlier, the dental role.

Thank you.

The CHAIRMAN. Thank you very much, Dr. Filerman.

[The prepared statement of Mr. Filerman follows:]

PREPARED STATEMENT OF GARY L. FILERMAN, PH.D.

Senator Kassebaum and members of the committee, I am Gary L. Filerman, Ph.D., Associate Director of the Pew Health Professions Commission. The Commission is an independent body established in 1989 by The Pew Charitable Trusts with the objective of helping to bring the education and training of health professionals into sync with the health needs of the American people through the emerging health care system. It is an enormous task involving many stakeholders and it is easy to say that the challenge is too big, and too complicated, and so weighted with tradition and negative incentives to be virtually impervious to stimulus for change by anything but market forces, even if that does take 30 years.

There are, however, many reasons to be optimistic that the educational system can reengineer itself, and indeed evidence of progress. The federal government is a factor both in the progress and in the resistance to change. But the programs which you are addressing today have been positive forces for change, I think well beyond the credit they usually receive. In my opinion the federal role can, and should be redesigned to more directly support our market-driven system, building upon the

previous federal investment, a team in the U.S. Department of Health and Human Services (HHS) Bureau of Health Professions (BHP) which has demonstrated leadership competence, and the foundation of the extant programs in Titles III, VII, and VIII. In other words, "don't throw out the baby with the bath water."

The recommendations which follow are my own, but draw extensively upon the findings, experience and recommendations of the Pew Commission's six years of work.

The most essential point and premise is that there is an essential and appropriate federal role in facilitating change in health professions education. The government as purchaser has a prudent buyer stake in the workforce. Health cost containment depends in no small part on having the appropriate workforce in the right place at the right time. Education is ultimately the largest vendor to Medicare and Medicaid—indeed some of the most daunting barriers to change are embodied in the ways those programs recognize that interdependency. And health professions education has a long shelf life—we are investing now in career patterns, specialties and competencies which will endure for 40 years.

That is the second argument for the federal role—the federal government has had a profound impact on the current situation—it will not be fixed by pulling back, but by well-informed, agile, targeted and measurable strategies which will reduce barriers and facilitate the maturity of the market. I would add careful to the criteria because the strategies must be designed to protect the qualities of the educational enterprise as it transitions to meet the nation's needs. I think that there is a way to do that.

Current programs should be consolidated into six strategic directions which have clear and measurable objectives which are continuously evaluated from the perspective of their contribution to strengthening the market. Size of a program is not the issue—smallness is as likely to be a strength as it is a weakness.

The six strategic directions are:

(1) To provide leadership to the effort to assure that the nation has an appropriate health workforce as soon as possible.

(2) To stimulate education and the professions to provide professionals and the primary care competencies which are the key to the emerging "health," not medical care system.

(3) To expand participation in the health workforce by all of our communities, not only because disadvantaged minorities are underrepresented but because the health system is not positioned to effectively serve an increasingly culturally diverse nation such as ours.

(4) To strengthen the nation's capacity to protect the public health and improve health status through an infusion of competencies into our creaking public health infrastructure, and by meeting the increasing demand of the market for wellness expertise.

(5) To facilitate market force changes through the production and dissemination of much better information on all aspects of the workforce including supply and demand and solid assessment of the value-added of various kinds of health workers.

(6) Underpinning all of the above by a system of workforce development—student assistance and a National health Service Corps which is directly supportive to the strategic directions which I have outlined.

LEADERSHIP

In the past three or four years, HHS has demonstrated the ability to provide national leadership that informs and facilitates workforce change without being regulatory or heavy handed. The result is that useful information has been disseminated where it can be used to make better decisions, exchanges among key players have been facilitated by convening them, and both publicly and privately supported innovations have been disseminated into the marketplace of ideas. This role is clearly a "best buy" for the government. It should be encouraged and enhanced, particularly in partnership with the private sector.

I recommend the establishment of a health workforce advisory board charged with advising the Congress, the President, and the public on all aspects of workforce status and development. The board would have a limited life of six years, replace the existing medicine and nursing councils, have a majority of members from the health services industry, the public, and the states, and be staffed by the BHP. With a broad market perspective, the board would set goals and measure the progress of both public and private efforts to reposition the workforce.

In particular, the board should seek opportunities for collaboration between the federal government, state governments, and the private sector. A focal point for dialogue between supply (education), and demand (employers, the states, and the fed-

eral government) would expedite responses by education. The Pew Commission and HHS recently partnered in facilitating such a dialogue on allied health workforce development which demonstrated a successful public/private partnership toward a better informed workforce market. Its success was due as much to leadership as to money. Much more can be done in the same spirit.

The board should also monitor and advise the programs which I hope the committee will authorize. This will assure the Congress that the federal investment has the benefit of continual well informed input from the market.

The Council on Graduate Medical Education (COGME) and the National Advisory Council on Nurse Education and Practice (NACNEP) have made contributions to the leadership role of HHS which far outrun the resources they have had to work with. They have demonstrated the potential which I would argue should now be more fully realized in the interest of responding to a market driven health system.

PRIMARY CARE WORKFORCE

There is increasing evidence of market forces deploying more primary care providers, but the supply of these providers remains a barrier. Titles VII and VIII programs are making substantial contributions to reducing that barrier, but can do more. In particular, my suggestions are that:

The effort to expand family medicine programs and residencies be given priority.

Nursing education resources be targeted at twin objectives: expanding existing masters degree programs for advanced practice nurses and nurse midwives, and encouraging baccalaureate nursing education to focus upon home health, community based care, and long term care. The graduate medical education (GME) funds now going to hospital schools of nursing should be similarly invested.

There is an urgent need for the federal government to stimulate accessible retraining programs for both physicians and nurses. If the government is going to continue to support the training of specialist physicians and hospital nurses now in over supply, support for retraining is eminently logical.

The most overlooked resource for facilitating workforce adaptation to the emerging market is the continuing medical education (CME) system—the one way to reach most practitioners. I would work with university-based CME programs to capture their energy and talent for disseminating the essential competencies to make the new system work. CME needs a lot of improvement to maximize its effectiveness but there is no alternative for impacting upon the practitioner. The university CME system, which should serve physicians, physician assistants and nurses, is distinct from the commercial CME system which is unlikely to address this need.

PARTICIPATION BY ALL AMERICANS

Progress has been too slow and should be more responsive to the emerging demographic profile of America. There is a real danger of cultural and ethnic communities disconnecting from the health system if providers are not representative of those communities. Current programs and priorities should be closely scrutinized by the Health Professions Development Board to assess their effectiveness from the market perspective, and if appropriate, to encourage more public/private collaboration in attracting a broader spectrum of ethnic backgrounds to health careers.

THE PUBLIC HEALTH

As we move further into a managed care system with incentives for improving the health of defined populations, a long cherished dream becomes achievable—a system which actually invests in health as vigorously as it invests in medical care. The catch is that we don't have the people with the competencies to fulfill the dream. In fact a perverse process is at work—managed care organizations are hiring away scarce public health professionals from health departments which are already very thin on essential skills.

The health departments of states, counties, and cities will undergo change along with the system, giving up many of the public hospital and clinic functions they acquired as a safety net. But the core functions will remain and grow with the population and, in fact, may assume a greater burden in an era of deregulation.

There has always been a shortage of public health professionals. The educational system must be expanded, but not only by more of the same. The needs of government agencies and the managed care market can be met through the development of an undergraduate level program which will cost effectively prepare thousands of competent professionals. The graduate schools of public health can then concentrate on what they do best—preparing teachers, managers, and researchers. In my judg-

ment, this is a long-overdue direction which should be established by federal initiatives.

Secondly, public health practice is a logical career direction for the thousands of physicians and nurses who are being displaced by the growth of the managed care system. Along with primary care, public health is the logical and timely focus of retraining, which can be undertaken by the graduate schools. It will take a federal investment to establish the capacity and the support to do it, a very appropriate federal role.

THE ROLE OF INFORMATION

As in any market, information drives decisions by students, schools, employers, professional bodies, states and the federal government. The events of the past year illustrated how weak our health workforce information base is. It is really quite remarkable how much we do not know. The inadequacy of information is an impediment to market forces. Certainly students would make better decisions about their careers, and demand more responsive schools if they had access to solid supply and demand information. Schools would make better decisions as would trustees of universities and legislatures.

There is both a direct and an indirect federal role in the production and dissemination of workforce information. The former includes much of the work pioneered by HHS, but which has been starved for resources in recent years. No other agency or entity can provide the framework and standardization which is essential to a credible workforce data base. The indirect role is again in the realm of leadership—working with the states and the professions to encourage technical collaboration and to assure access to this vital information. The BHP has done excellent work of both kinds and should be encouraged to expand these efforts, with more emphasis upon dissemination.

There is a critical void in all of these efforts which must be addressed with alacrity. The proliferation of health professions at all levels with all of the rigidity that go with it has created a series of intertwined barriers to cost effective task allocation in the marketplace. We simply do not know what the value added is of many occupations, specialties and subspecialties which were born in the era of unlimited cost reimbursement. This is a priority target for outcomes studies which could be supported through Titles VII and VIII and/or in the Agency for Health Care Policy and Research.

WORKFORCE DEVELOPMENT

I would emphasize the important role of the National Health Service Corps, a very successful program. It has been criticized for not doing what it was not intended to do, namely, permanently placing professionals in shortage areas. The extent to which Corps graduates remain in their communities is a bonus. The point is that the Corps works—but the other fact is that it has not received the commitment which it deserves.

This program should be continued and provided greater incentives for students to choose primary care and public health roles. The Corps scholarships, loan repayment and community scholarship program should be funded to expand the program to serve all designated shortage areas by the year 2010. The Corps would be made more attractive by excluding loan repayment awards from gross income for tax purposes, and by encouraging the states to do the same.

The Pew Health Professions Commission and the Bureau of Health Professions have established an excellent working relationship which has leveraged both of our resources. We have had the opportunity to examine Titles III, VII, and VIII clearly from the perspective of the public interest and believe that they have made important contributions and that, with appropriate redesign and evaluation, will continue to do so.

The Pew Commission is prepared to offer more comprehensive and detailed recommendations for the committee's consideration at any time. I cannot emphasize enough that with fundamental education and workforce reform, the health workforce will become the foundation for an efficient, high quality and equitable new system.

The CHAIRMAN. Dr. Tuckson.

Dr. TUCKSON. Thank you very much, Madam Chair and members of the committee. It is a privilege to be able to discuss some of these issues with you.

My name is Dr. Reed Tuckson, and I am president of the Charles R. Drew University of Medicine and Science. Today I also come before you in my capacity as president of the Association of Minority Health Professions Schools, the association representing the 11 historically black medical health professions schools in our country.

I have had the privilege of spending my career struggling with the provision of health care to poor and underserved communities throughout this Nation. My experience makes me painfully aware of the extraordinarily painful and inappropriate, disproportionately poor quality of health for so many of our minority communities and poor communities in this country.

I am here this morning with the full knowledge that today, people are dying who should not die. In fact, 70,000 African Americans alone will die prematurely this year in excess of how many would have died if the health of black Americans were the same as for white Americans—70,000 people will not be on the planet this time next year who would be, should be, could be, if their health were the same as for white Americans. And that does not even begin to speak of our Latino brothers and sisters, Native Americans, poor rural white Americans. This is an extraordinarily important issue, and the diseases that account for it—heart disease, cancer, diseases of chemical dependency, infant mortality, diabetes, HIV disease—these are diseases that we can do something about if we had the appropriate practitioners working in our communities with the appropriate support.

I will say to you that it is an extraordinarily important issue that we must address. The poor health status of minorities and their residence in poor communities is mirrored by a simultaneous shortage of health professionals who are willing and competent and who are prepared to serve in underserved communities.

Similarly, while black Americans, for example, are 12 percent of our population, only 2 to 3 percent of the components of our health professions are African Americans—only 2 to 3 percent of the doctors, the nurses, the physicians, the allied health professionals, the veterinarians and the pharmacists are African Americans— people who really should be there to go back to their communities and be able to address these horrible tragedies.

The national priority that exists to improve the health status of minorities rests in large part on our ability to train competent and dedicated individuals to serve our Nation's underserved communities.

Our experiences, members of the committee, and our outcomes analysis tell us that individuals who come from disadvantaged backgrounds or underserved areas are much more likely to serve in an underserved area as health professionals. Increasing the number of well-trained health professionals to serve in underserved areas can and does improve health status.

That is why the role of historically minority health professional schools is so critical. We have a collective mission to train minorities to serve in underserved areas. That is what we exist to do. We also have the track record and the statistics to demonstrate that our programs are working.

For example, our 11 schools to date have trained 50 percent of all the physicians, 50 percent of all the dentists, 50 percent of all

the pharmacists, and 75 percent of all the veterinarians who are black in America. Our 11 schools have done that to this point in time.

Many of the health professions training and institutional support programs being reviewed today have had and continue to have a dramatically positive impact on the ability of our schools to train the health professions work force that is needed to solve our problems. So it is extremely important, then, that I bring to your attention two issues of particular importance that are under discussion in this very important bill that you are bringing before us today.

First, student financial assistance. We support the idea of some streamlining of student aid programs, but we would strongly urge you to continue the scholarships for disadvantaged students program to allow for modest, school-based programs to ensure that the poorest of our students can become physicians, dentists, pharmacists, veterinarians and allied health professionals. There is a desperate need for this committee to understand that scholarship support is the only way to a health professions education for severely disadvantaged students.

Student aid officers tell us time and time again that poor students will not agree to incur debt for tuition cost that is about twice the level of their family's annual household income. So the effect of wiping out all scholarship support is to ensure that poor people do not become health professionals.

While we support and celebrate, and have been here before to celebrate, the role of the National Health Services Corps, our experience suggests that it is counterproductive to force all poor students to serve in the National Health Service Corps as the only way of receiving Federal financial assistance.

Let us consider things like serving on the faculties of schools like ours; let us talk about being involved in research to solve the pressing health problems of underserved communities as ways also of justifying financial support.

Second and finally, in regard to the Minority Centers of Excellence, the four specific institutions that are currently designated as Centers of Excellence in the legislation—Meharry Medical and Dental Colleges, Xavier Pharmacy School, and Tuskegee University School of Veterinary Medicine—each are private institutions that receive little State funding, and because their mission is to train disadvantaged minority students for service in underserved areas, they have struggled desperately to survive financially. They do not benefit from a wealthy financial or donor base. Located in poor communities, the people who participate in their clinical practice programs are also poor and without insurance. So that while most medical schools get 40 percent of their budget through the clinical practice of medicine, they get 2 percent to 3 percent of their budgets. They are struggling desperately to survive, and despite that, they are doing well; they are able to recruit new students to come to them. They are able to educate those students, and they are able to retain those students. In large measure because in the wisdom of this committee, what it has done historically is to allow them the chance to participate in the Centers of Excellence program. So they have delivered the outcomes that are so important to you.

I will submit for you my written comments in the record, as well as an analysis of some of the specific outcome measures such that you might have more confidence and be able to celebrate the beautiful benefits that this committee in fact has already brought to this country.

I thank you for this chance.

The CHAIRMAN. Thank you very much, Dr. Tuckson.

[The prepared statement of Dr. Tuckson follows:]

PREPARED STATEMENT OF DR. REED TUCKSON

Madam Chair and members of the committee, thank you for the opportunity to discuss minority and disadvantaged health professions training and the health professions reauthorization.

I am Dr. Reed Tuckson, President of Charles R. Drew University of Medicine and Science located in South Central Los Angeles.

Today, I speak with you as an individual who has focused my career and experiences as a physician, academician, and public health official on serving the disadvantaged in underserved locations, and as the President of an institution that has a mission to train health professionals who are dedicated and competent to serve the health needs of underserved communities. Drew University is one of 11 historically Black health professions schools that comprise the Association of Minority Health Professions Schools.

I am a graduate of Howard University and received my medical degree from Georgetown University. I have served as Commissioner of Public Health in the District of Columbia, on the board of the American Public Health Association, and have been very active in health policy issues related to underserved communities.

THE HEALTH STATUS OF MINORITIES

Madam Chair, African Americans and other minorities suffer a disproportionately lower health status when compared to their non-minority U.S. citizen counterparts. Instead of improving, like that of non-minorities, African American's and other minorities' health status is deteriorating.

Here are some current indicators of minority health status derived from the 1993 update of the 1985 Health and Human Services Secretary's Task Force Report on Black and Minority Health.

—African Americans suffer almost double the rate of infant mortality of whites.

—African Americans and Native Americans incur a disproportionately high rate of some cancer, diabetes, hypertension, and stroke compared to nonwhites. Hispanics are twice as likely to suffer from diabetes compared to the general population.

—Annually in the United States, approximately 70,000 excess deaths occur among African Americans—that is 70,000 African Americans who would not die each year if their life expectancy and death rates were the same as whites.

—The injury death rate for African American children ages 1–14 is 55 percent higher than for white children. The injury death rate for Native Americans is also very high.

—Twenty-nine percent of all U.S. AIDS cases are among African Americans, who represent only 12 percent of the American population. While Hispanics represent 9 percent of the U.S. population, 16 percent of AIDS cases occur among Hispanics.

—33 percent of Hispanics and 22 percent of African Americans do not have health insurance coverage, compared to 14.5 percent of whites.

—46.6 percent of U.S. African American children, and 33.1 percent of all U.S. African Americans live below the poverty level.

The poor health status of minorities is mirrored by a simultaneous shortage of minorities in the health professions. While Blacks represent 12 percent of the U.S. population, only 2–3 percent are health professionals.

Madam Chair, and members of the committee, it is my hope that these statistics convince you that the playing field is not level, and that there is a need for targeted federal support to eliminate some of these disparities.

THE ROLE OF HISTORICALLY MINORITY SCHOOLS

The national priority that exists to improve the health status of minorities rests in large part on our ability to train competent and dedicated individuals to serve our nation's underserved and disadvantaged areas.

Every credible study ever conducted demonstrates that an individual who comes from a disadvantaged background or underserved area is much more likely to serve in an underserved area as a health professional. Increasing health professionals to serve in underserved areas can and does improve health status. That is why the role of historically minority health professions schools is so critical. We have a collective mission to train minorities to serve in underserved areas. We also have the track record and statistics to demonstrate our programs are working.

The Charles R. Drew University of Medicine and Science is one of four historically Black medical schools in the United States. Along with Meharry Medical College, Morehouse School of Medicine, and Howard University School of Medicine, our four schools train virtually half of the Black physicians in the country. The schools of dentistry at Meharry and Howard train half of the African American dentists in the United States. Four colleges of pharmacy, Xavier of Louisiana, Florida A&M, Texas Southern and Howard train practically 50 percent of the African American pharmacists in this country. The one African American college of veterinary medicine, Tuskegee in Alabama, historically has trained approximately 75 percent of the nation's African American veterinarians. Many have called the 11 schools of our Association a national resource.

TARGETED SUPPORT FOR IMPROVING MINORITY/DISADVANTAGED HEALTH

Members of the committee, it is our hope that Congress will continue to recognize the importance and significance of targeted support to institutions that can demonstrate historic and program activity that helps to solve the problem of poor health status among disadvantaged and minority populations.

Many of the health professions training and institutional support programs being reviewed today have, and continue to have a dramatically positive impact on the ability of our schools to train the health professions workforce that will serve in underserved areas and improve the health status of disadvantaged and minority populations. We support the continuation of this targeted support, so we can continue to contribute to improving health status.

TWO PROGRAMS OF CRITICAL IMPORTANCE

Madam Chair and members of the committee, there are two programs of critical importance that I must bring to your attention that must be continued to make progress in our goal to improve the health status of disadvantaged populations.

1) Student Financial Assistance

We support some streamlining of student aid programs but strongly urge continuation of the Scholarships for Disadvantaged Students program to allow for a modest "school based" program to insure that the poorest of students can be physicians, dentists, pharmacists, veterinarians, and allied health professionals.

There is a desperate need for this committee to understand that scholarship support is the only way to a health professions education for severely disadvantaged students. Student aid officers tell us time and time again that poor students will not agree to incur debt for tuition costs that is about twice the level of their family's annual household income. So the effect of wiping out all scholarship support is to ensure that poor people do not become health professionals.

While we support and celebrate the continued enhancement of the National Health Service Corps (NHSC), our experience suggests that it is counter productive to force all poor students to serve in the NHSC as the only way of receiving federal financial assistance.

2) Minority Centers of Excellence

To a great degree, the targeted federal support to which I refer is embodied in the Minority Centers of Excellence program authorized in the Health Professions Disadvantaged Minority Health Improvement Act, the legislation that is the subject of today's hearing.

The four specific institutions that are designated as Centers of Excellence in the legislation, Meharry Medical and Dental Colleges, Xavier Pharmacy School, and Tuskegee University School of Veterinary Medicine each are private institutions that receive little state funding, and because their mission is to train disadvantaged minority students for service in underserved areas, each have struggled to survive financially.

They do not benefit from a wealthy donor or financial base. Located in poor communities, they serve the health care needs of their patients often without remuneration and certainly cannot compete with other institution's clinical revenue base. Nothing in either their history or contemporary experience suggests any resemblance of a level playing field in relationship to other universities with which they would be forced to compete if the committee's proposal were enacted.

Despite these challenges, the four original Centers of Excellence have demonstrated a historic expertise in training minorities to serve in underserved areas. Without these four schools the health status of minorities in the U.S. would be even more abysmal. Without the Centers of Excellence support, the very existence of these schools is in jeopardy.

The Centers of Excellence program works—and the reason it works is that policy makers, including yourself, have been bold enough to say these schools are unique, and are meeting a national need, therefore we should target support to them. We urge the committee to continue the special designation and funding for the original four Centers of Excellence.

I would like to submit for the record a comprehensive report from the historically Black health professions schools that details the outcomes and results from the Minority Centers of Excellence program, and Student Financial Assistance programs contained in the legislation.

Thank you for the opportunity to present our views, and I would be very pleased respond to your questions.

The CHAIRMAN. Dr. Kindig.

Dr. KINDIG. Thank you, Madam Chairman.

In addition to my current affiliations that you mentioned, I also chair the National Council on Graduate Medical Education, which advises the Congress and the Secretary on physician work force issues. In addition, I did my pediatric residency in a neighborhood health center in the South Bronx, and was the first medical director of the National Service Corps. I have cared about these issues deeply for my whole career, and I am really pleased to be invited to be before you today.

I have been primarily asked to address the generalist physician component of this proposal, but I share the opinion of Dr. Lee and my colleagues at this table on the importance of other programs such as the Area Health Education Centers, minority disadvantaged issues, nursing, and public health.

A person can only make a few points in 5 minutes. The four that I would like to emphasize are the following. First, poor physician specialty and geographic distribution and minority representation remains a significant barrier to health care access in 1995.

Second, in the past, Federal support has been a critical strategic investment—decisions made here in this committee—and needs to be continued to correct these physician work force deficiencies.

Third, in a time of scarce resources, consolidation and targeting of Federal efforts to achieve these outcomes is appropriate.

And fourth, linkage of Title VII and Title VIII health professions programs to Federal delivery programs in Title III and to HCFA graduate medical education support and other programs is an opportunity for additional synergism, and I will comment on that at the end of my testimony.

I have a few charts here that I will allude to briefly; they are also in my written testimony. These were prepared for me by COGME staff.

Figure 1 is actually the graphic representation of what you have heard before, that we did have major efforts underway to increase the supply of physicians in the United States, and it worked, but primarily resulted in a growth, almost a doubling of the number of specialists and moderate efforts to increase the number of generalists.

I think that much of the generalist growth that you see on this chart is responsible to programs under this legislation, particularly

the support of the development of family medicine, as well as in general medicine and general pediatrics over this time.

Recent data—and actually, I did this last week—we have known in the past that whereas generalists have increased more slowly, that they have increased in all areas of the country. But this chart shows that in 1993, some of our smaller communities—in fact, there has been an absolute decline as opposed to a slower rate of growth. I think that that underscores the fact that our job is not even done, and may be even giving us greater challenges.

I suspect this would also be true for inner city neighborhoods, but it is much more difficult to get national data at that level.

And then, finally, with regard to geographic distribution, the number of generalists positions required to eliminate Federal shortage areas remains approximately the same as it has been over time. The lower line shows the level needed to remove all primary care shortage areas from the designation list. This is what we tracked. I should point out to you that this is a minimal supply. When we did this back in the early seventies, it was about the bottom quartile of generalist to physician population ratios. That is what we track, and it remains about the same.

More recently, the Federal Government has been keeping statistics at a more adequate level, the top line, which is about 50 generalists per 100,000. Keep in mind that most HMOs have from 60 to 80 generalists per 100,000.

Lowering these numbers requires support such as in this legislation for targeted generalist physician education programs, as well as improving the infrastructure through community migrant health centers, National Service Corps, Medicare and Medicaid.

I do not believe it is possible to precisely separate the influence of each of these components, but I am quite certain they act in concert to keep the number of shortage areas as low as they are.

I have some comments here about the clustering, and maybe in the interest of time, I will not go into those in detail. I support the clustering proposal for the efficiencies that both you and the administration have in mind. I think there is always a tension, which I know you have struggled with, between categorical issues and clumping.

I really believe, along with Gary Filerman and others—and in COGME last year in our broader efforts, we were looking with your support at the issue of consortia, in other words, getting institutions pulling together as opposed to being totally categorical. So I guess I would say without a specific mechanism, I would favor institutional applications for as many of these components as possible.

I agree with Gary that we should not stick only to the generalist physician stuff, but include nursing, and frankly, actually, reach into Title III if you could. But I would underscore, however, that family medicine has been so important in this growth that we have achieved that their status, unfortunately, in academic centers is not, even 25 years later, fully firm and that most of their residencies are not in academic centers, so they probably require some special identification or a minimum level of support. I had a few other comments on that.

I also want to make one other narrow comment. For 10 years, I ran a graduate program in health administration. I do not believe that there is a role for general Federal support in that area, but I do believe that in the context of institutional applications, encouraging institutions to reach out to the management needs in rural clinics, in inner city clinics, particularly in light of Medicaid managed care and some of the neighborhood health center networks, is critical, maybe through distance education, and I would be happy to work with you more on that.

I would like to join Gary and Phil Lee on the issue of data development and outcomes research in this field. It is critical. One of the criticisms of the GAO was that we do not have enough outcomes evidence. It is difficult to do, but we also have not supported it. It has kind of fallen through the cracks. I know Dr. Lee is working on that. But I think there should be targeted support for data development and outcomes data in this field.

I would like to conclude with a few comments about the importance of linking the efforts of these consolidated outcomes-based authorities with other Federal programs that have the same or related goals, and here I am going to go down Senator Kennedy's line of questioning vis-a-vis Medicare and some other programs.

The best educational efforts will not succeed in attracting and retaining health professionals in needy areas if practice conditions and potential for adequate payment are not present. What you do here is necessary, but not sufficient.

Every opportunity for linkage and synergy with PHS programs under your authority needs to be found and incentives provided. Of particular importance are service delivery programs like community migrant health centers, the Indian Health Service, and the National Service Corps.

For example, as someone who did a residency in an OEO neighborhood health center in the South Bronx, I have never understood why we have not had strong incentive for more generalist physician and nurse clinician training in Federal neighborhood health centers.

Just as there are categorical program issues within academic health centers, I am aware of jurisdictional boundaries between committees of Congress. I realize that you do not have direct authority over Medicare and Medicaid programs, but the achievement of health professions distribution goals is in part or significantly related to incentives in these programs as well.

I would express hope that there could be some linking of these efforts, realizing particularly that Medicare GME policy is not now in alignment with these goals and that there are also opportunities during any kind of restructuring of Medicaid for States to enhance efforts made in the legislation. Examples might be up-weighting Medicare GME payments for primary care, reimbursing for training in ambulatory settings, including time spent in Title III or Indian Health Service sites, and reducing the number of residents supported by Medicare.

COGME is working on a formal position regarding this now. I expect that it will be in the spirit and direction of my individual testimony, and we will have a formal position paper on this in late April or early May.

I thank you for the opportunity to be here. I think this is a critical aspect of health care, where a strategic, targeted Federal investment role remains essential to provide quality and affordability health care to all Americans. I will be happy to work with you in the coming months if I can to help shape this proposal.

Thank you very much.

[The prepared statement of Dr. Kindig follows:]

PREPARED STATEMENT OF DR. DAVID KINDIG

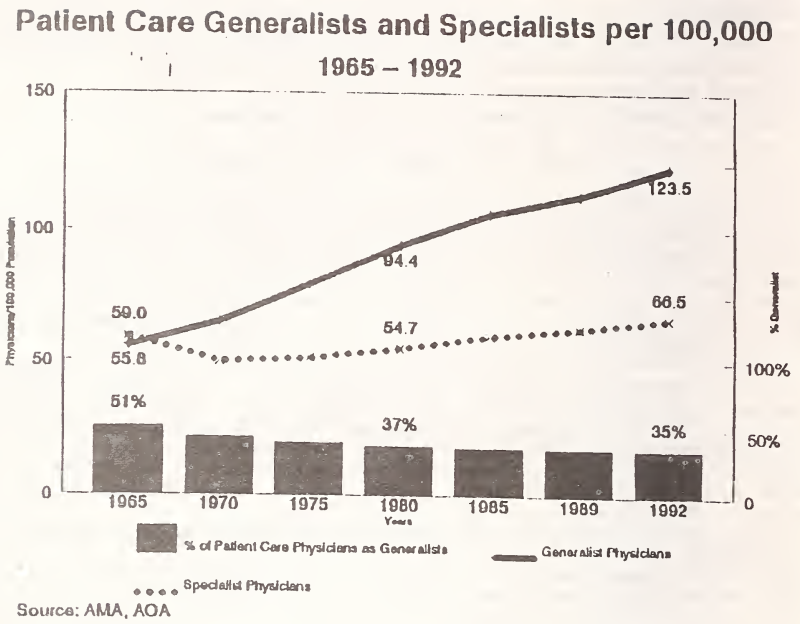
Madam Chairman and members of the committee, my name is David Kindig, and I am currently a Professor of Preventive Medicine and Health Policy at the University of Wisconsin-Madison School Medicine. I am also Chair of the National Council on Graduate Medical Education (COGME). I trained in Pediatrics in a neighborhood health center in the South Bronx, served as the first Medical Director of the National Health Service Corps, was Deputy Director of the Bureau of Health Manpower in the mid 1970s, and have held several senior managerial positions in the private and public sector.

The major theme that has run through my managerial and academic career has been that of insuring an adequate and appropriate supply of well-trained health professions to rural and inner city areas, and I am, therefore, pleased to be able to participate in this important hearing. I have been asked to address primarily the physician component of your proposal, but I share the opinion of my colleagues at the table that the other clusters of programs are very important as well. There are only a few points that one can make in 5 minutes, and I would like to be clear at the outset on what they are:

1. Poor physician specialty and geographic distribution remains a major barrier to health care access.
2. Federal Support Has Been a Critical Strategic Investment and Needs to be Continued to Correct These Physician Workforce Deficiencies.
3. In a Time of Scarce Resources, Consolidation and Targeting of Federal Efforts to Attain These Outcomes is Appropriate.
4. Linkage of Title VII and Title III Health Professions Support to Federal Delivery Programs and HCFA Graduate Medical Education Support is an Opportunity for Additional Synergism.

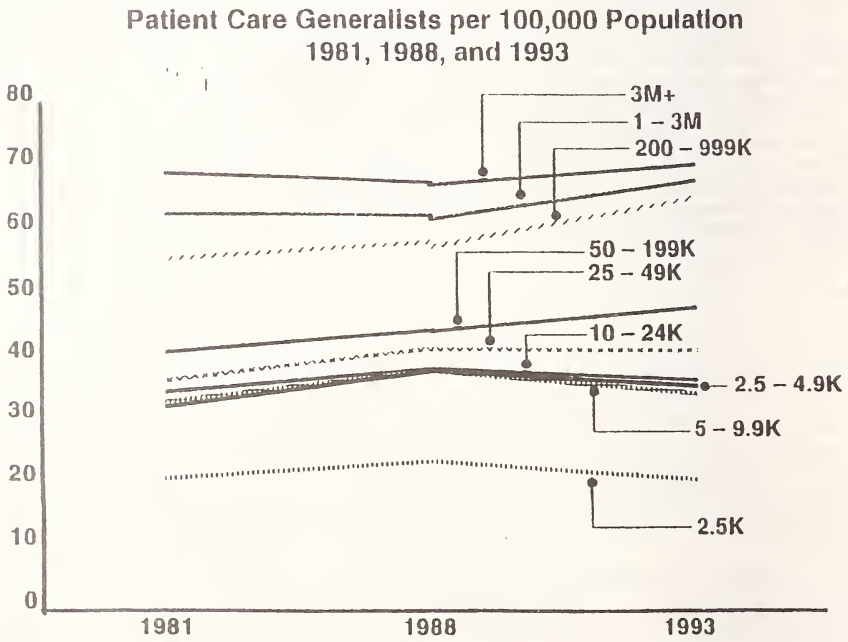
Let me return briefly to each point and amplify a bit with supporting evidence. Two major goals of national workforce policy and this legislation have been to provide increased numbers of generalist physicians in the entire country, and particularly in underserved inner city and rural areas. Figure 1 from COGME data shows how the numbers of generalists and specialists per 100,000 population has increased since 1965. While financial and academic incentives have produced striking increases in specialists, the numbers of generalists have increased as well, but much more slowly. Much of this is due to the growth and development of family medicine, as well as general internal medicine and pediatrics over this period, in large part due to funds from the legislation we are discussing today. Recent data indicates (see Figure 2), however, that the smallest and most rural counties are actually declining slightly in generalist physician to population ratios while other areas continue to increase.

FIGURE 1



Source: AMA, AOA

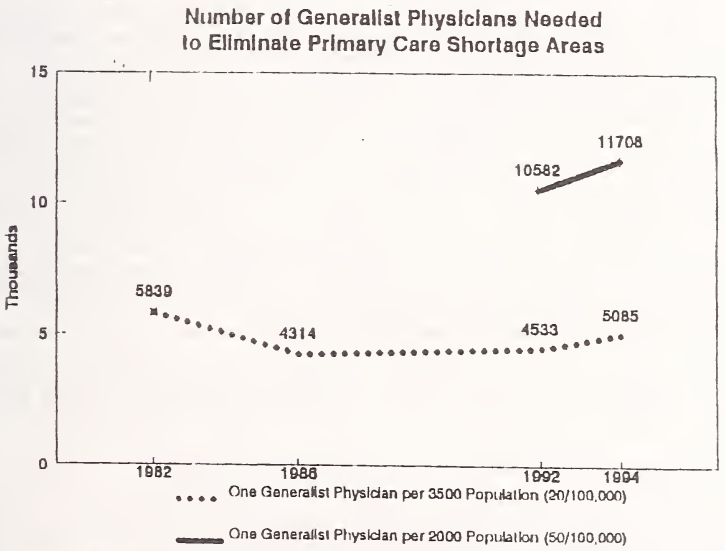
FIGURE 2



With regard to geographic distribution, Figure 3 shows continuing special needs for generalist physicians in federal rural and urban shortage areas. The lower line shows the level needed to remove all primary care shortage areas from the designation list; this is a minimal level of supply at about 29/100,000. The top line is the number needed to bring these areas to a more reasonable 50/100,000 (for comparison, most HMOs have from 60 to 80 generalists per 100,000 population). Lowering these numbers requires support for targeted generalist physician education programs, as well as improving the infrastructure through community/migrant health centers, the National Health Service Corps, and Medicare and Medicaid programs. I do not believe it is possible to precisely separate the influence of each of these components, but I am quite certain that they have acted in concert to keep the number of shortage areas as low as they are.

In these times of scarce resources, it is important to look for new ways to achieve efficiency in meeting these objectives, and the consolidation, clustering and outcome-based approaches in both your bill and in the Administration proposal have merit and are welcomed. The issue of set-asides within a consolidated area as opposed to a fully competitive process is a difficult one. There is a tension between breaking down categorical boundaries that can be barrier to innovation and efficiency, while at the same time remembering the cardinal principle of medicine, "First do no harm". The latter is particularly important with regard to family medicine, which has been responsible for many of the gains in access to health care that have been made over the past two decades, particularly in rural areas. I would have hoped that this new specialty would be solidly established in academic health centers in 1995, but this is not yet the case in many places; in addition, the majority of family medicine residencies are in community hospital settings. On the other hand, many inner city underserved areas are dependent on general internal medicine and general pediatrics since family medicine has not been fully established in academic medical centers in many urban areas.

FIGURE 3



Source: HRSA, AMA

The idea of applications from training network crossing disciplines and settings, as envisioned in the Administration proposal, has appeal as well. Too often, one part of an academic health center, such as a nurse practitioner or a physician assistant program, may be working in isolation from training in family medicine, while both have the same goals and would benefit from common efforts. I do not have a specific solution to this dilemma today, but in general would favor a priority for institutional applications, including Title VII and VIII efforts as well as linkages to Title III, which demonstrate a common effort designed to produce local measurable outcomes. I would, however, indicate a minimum level of support for family medicine depart-

ments and residencies, on the basis of their effectiveness in the past and recognizing that many of their residencies are not part of broader academic institutions.

As Chair of COGME, I must note that our authority sunsets in September and I understand that you intend to reauthorize COGME. We believe our track record of analysis and policy development in this area warrants reauthorization for an additional five years. Our independent status reporting both to the Congress and the Secretary, while being housed within the Department, has added credibility to our efforts. We do operate without a specific appropriation, making it difficult for HRSA to find the staff and resources for our functioning. I would ask that consideration be given to a designated budget, to allow for even more useful efforts in the future. If an oversight of the competing allocations between specialties and disciplines mentioned above would be helpful, you might consider assigning this responsibility to COGME.

I would also like to make a plea for some resources set aside for data development and research into workforce issues. We are hampered by lack of information in many of these areas; for example, most of the research about the substitution possibilities of nurse practitioners and physician assistants for generalist physicians goes back to the mid 1970s; there is almost no information on such substitution for specialists. I know Dr. Lee is aggressively working with HRSA and AHCPR to address these issues, and I think it would be very important to have some resources identified for analysis and monitoring of outcomes.

I would like to conclude with some comments about the importance of linking the efforts of these consolidated, outcome-based authorities with other federal programs that have the same or related goals. The best educational efforts will not succeed in attracting and retaining health professionals in needy areas if practice conditions and potential for adequate payment are not present. Every opportunity for linkages and synergy within PHS programs under your authority need to be found and incentives provided; of particular importance are the service delivery programs like C/MHS, the IHS, and the NHSC. For example, as someone who did a residency in a federal neighborhood health center, I have never understood why more graduate medical education has not been developed in such settings.

Just as there are categorical program issues within academic health centers, I am aware of jurisdictional boundaries between Committees of Congress. I realize that you do not have direct authority over the Medicare and Medicaid programs, but the achievement of the health professions distribution goals is in part dependent on incentives in these programs. I would express the hope that there could be some linking between these efforts, realizing that Medicare GME policy is not now in alignment with these physician workforce goals and that there are also opportunities during restructuring of Medicaid for states to enhance the efforts made in this legislation. Examples might be upweighting Medicare GME payments for primary care, providing reimbursement for training in ambulatory settings including time spent in Title III or IHS sites, and reducing the total number of residents supported by Medicare. COGME is working on a formal position regarding how both PHS and HCFA efforts can be further aligned in support of COGME workforce goals. I expect that these recommendations will be in the spirit and direction of my individual testimony today, and will be forwarded to you in early May.

Thank you for the opportunity to make this statement. You are engaged in a critical aspect of health care where a strategic, targeted federal investment role remains essential to provide quality and affordable health care to all Americans. I will be happy to work with you and your staff over the coming months in support of your approach and will be pleased to take any questions which you or the Committee might have.

The CHAIRMAN. Thank you very much, Dr. Kindig.

I will ask a couple of questions—and certainly, any one of you please feel free to answer—but since you had some charts on generalists and specialists, Dr. Kindig, from your perspective, which of the health professions have the greatest shortages as you have looked at this in your research?

Dr. KINDIG. Well, I will admit that most of my own research and the work of COGME, which I know the most, has really been in the generalist physician area. There are important interrelationships. There is no question that the need for nurse clinicians and physician's assistants and professionals in public health sort of operate synergistically. And frankly, one of the research issues that

we need to get into is how do we model integrated work force requirements because it may not be a zero-sum game, but it is a sum game of some kind or another, and even in the generalist area, we probably do not need to dramatically increase all kinds; we need to look for the right balance.

Frankly, Madam Chair, I really have less research expertise in areas like the need for dentistry and some of the other issues. I know that in certain areas, they remain critical, but in terms of a national picture, I think I would defer to others on that.

The CHAIRMAN. Dr. Filerman.

Dr. FILERMAN. I do not think this is the answer you are looking for——

The CHAIRMAN. Well, I was just curious.

Dr. FILERMAN. I think, Senator, that the health professional that is in greatest shortage probably does not exist yet, and that is a hybrid or a combination health professional that is going to be able to go into people's homes and provide the integrated services that are going to keep them there at low cost, keep them out of the hospital, enable them to use all the new technologies that are being brought into the home.

We are moving helter-skelter toward a much stronger emphasis on home care, but the work force structure is not related to that at all. There is no reason to send five different health professionals into somebody's home. That is not going to save any cost, and it is not going to result in integrated care. We need an integrator and a facilitator, and it has got to be someone who is not at the technician level, because they have got to be able to make independent judgments; otherwise, the institutional system is going to be carrying much too much of the freight. And our present work force, as I said, is all focused on that institutional system.

The CHAIRMAN. You mentioned, Dr. Kindig and Dr. Tuckson, the underserved area and the neighborhood health center. We have talked for years about how to get people back into these areas to serve. There have been scholarships; various States have incentives in their medical education programs, and it really has not—I do not think—proven to be terribly successful overall. So that while we all talk about it, I think we have not found the magic bullet yet, it seems to me.

Dr. Tuckson, you have worked very closely, and you have great outreach at Drew Medical to the surrounding community, but do you find that your doctors and nurses are going into the underserved areas and are working in the neighborhood centers?

Dr. TUCKSON. Absolutely. That is exactly what we are finding. In fact, our students come to our schools—not only mine, but also the others of our associations—for the specific purpose and knowing that that is why they are there. We are not training people to be plastic surgeons on Rodeo Drive. They know it when they come.

What we are also experiencing is that as I look around at the junior faculty that we have, and I look at the junior faculty who are now training the new kids that are coming up, we trained that junior faculty, or they were trained at Morehouse, or they were trained at Meharry. So that we are sharing, and we are seeing that success.

But the larger issue, Senator, is that while we have been trying, we have not tried in a mature and consistent way. We pulled the plug on the National Health Service Corps programs a few years back, and so just as we started to get there, we said we were not going to invest in this anymore. Now we are retooling, and now it will take 5 years to catch up.

What I would briefly suggest and hope is that we would have a mature program and the resolve to stay in there for the long run.

And the last thing, Senator, because you are particularly astute to this, is that we know there are no simple answers, no simple solution, no one bullet that is going to do it, and you know it. You know it is going to be because we are going to combine the early childhood education programs for children in the inner cities. Like in our place in L.A., which you came out and saw, we have kids in early childhood education, in a Saturday science academy for kids 6 to 14, in a medical magnet high school, then allied health school, medical school, and postgraduate. It is that kind of comprehensiveness that is required if we are going to solve complex problems.

The CHAIRMAN. My time for questioning is about up. You three are very strong advocates for all that we should be caring about here.

You mentioned the scholarship program for minorities, and I just want to tell you that we are working with Senator Kennedy—to provide language in the bill, when it is introduced in support of those scholarships.

You mentioned the Centers for Excellence, and we have removed that set-aside, so to speak, and they will have to compete for funds. My feelings on set-asides are that those programs that have offered quality and extraordinary service do need support, and I tend to believe they can compete successfully; thus, I do not worry about them not getting the necessary money. But everybody wants a set-aside for protection, and I just think we have to be willing at some point to look at that.

But if I may just carry on, another question of real sensitivity here is whether the funding of programs to increase minorities in the health professions represents a form of affirmative action. Dr. Tuckson, you care about this, I care about this; it is an issue that has been raised a great deal today. Why do we need to do this with the scholarship program? Can you answer it in the light of whether this is or is not affirmative action, and how important is this?

Dr. TUCKSON. It is an interesting question. In terms of the issues of affirmative action, what I know is this, that there is an extraordinary need for the health professionals that those schools are training. In those communities, for Tuskegee, for Meharry, and for Xavier, where they are working, there is a tremendous need for the student products and the intellectual products of those schools. And I hope you are right that they would be able to compete well in the larger pool.

The inevitable result is that after finally investing in them and getting them to the point where there is a faculty that is now coming into place, where there are library systems that are starting to work, where the recruitment efforts are there, where finally as a nation we have invested and gotten them to the point where they

are almost able to be self-sufficient—and we pull the plug again, and the ball rolls right back down to the bottom of the hill. Then, 2 or 3 years later, we come back, and you ask the same question again—we have tried things, and why don't we have enough to show for it?

So it is the same—I think we have to have that maturity of vision that looks to longer run and not short-term interventions, because ultimately, you will not get the return on the investment that is necessary.

As far as the affirmative action implications of the question, that is something I will have to think about, but I just know this, Senator Kassebaum, that if we get into the affirmative action conversation, I think we will not pay attention to the fact that we have poor people who are in desperate need of help today, and we will get blindsided by another whole set of issues which will dilute from the screams that I can hear in my mind's eye at this very moment from unnecessary, preventable disease in those communities—and that is the only thing that counts.

The CHAIRMAN. Thank you. That is a very strong statement.

Senator Kennedy.

Senator KENNEDY. Dr. Tuckson, it is good to see you. Just on this point, as I understand it, the funds that actually go to the schools are distributed in a nondiscriminatory way, and the basis is the underserved nature of the community or the disadvantage in terms of the applicant. Do I understand that correctly?

Dr. TUCKSON. For the majority of the program, that is true. There is a set-aside for four schools from which this program evolved, so there was a beginning recognition by the Congress, signed by President Reagan, in fact, that there were four schools that had specific need, and that was the origin of it.

But I think what is important about your question, sir, is that one of the key elements here is that these are all competitive programs now, and that to be able to qualify for the programs, even for the four that I am particularly talking about, you must in fact compete and must be evaluated and be successful. The bottom line is that for the rest of them, it is very competitive.

Senator KENNEDY. But once the funding goes to the schools, then it is on the basis of need.

Dr. TUCKSON. Oh, yes.

Senator KENNEDY. Could you just elaborate on that for the record? It is on a nondiscriminatory basis, on the basis of need, am I correct, for disadvantaged communities and students from disadvantaged backgrounds, and whites participate as well as blacks; is that correct?

Dr. TUCKSON. Absolutely. It is specifically multicultural. One of the hallmarks of the institutions that are under discussion is that they are in fact very diverse institutions, and that is one of our strengths, in fact.

Senator KENNEDY. Very briefly, as I understand it, the basic concept of the structure, you are basically supportive of—let the record show all three panelists nodded affirmatively—some perhaps a little more affirmatively than others.

I would appreciate it, as you go on through and as we do, if you would let us know about the areas that you are most interested in and supportive of.

And finally, I will just say that I agree with Dr. Tuckson. Dr. Lee pointed out very quickly and very briefly the dimensions which are necessary to get people in underserved areas. You have to be conscious of the fact that the people who are going to go to those areas want to be able to practice the best medicine, want to have the best equipment, want to have the best-trained personnel to support them, do not want to have great disparities in terms of resources as far as how they will be considered versus the rest of the medical profession, so that they can maintain a high degree of medical competence in relationship to their classmates and their peers in these areas, so that continuing education and training programs are right up there. And then, as Dr. Lee mentioned, they want access in terms of schools for their children, or whatever the other factors and practice incentives are that are important and that do not lend themselves as quickly in terms of obvious legislative solutions.

But we did see with the National Health Service Corps, in which I was involved with Senator Magnusen, who was a real leader in this area, that it was effectively wiped out, zeroed out, in the early 1980's and gradually built back up and enhanced over a period of time. We have seen those kinds of pressures, and level funding for the neighborhood health centers over a period of time and the challenges they have faced.

Rather than going through those, let me ask you this and get just a brief comment from each of you. What is happening in the underserved areas? The kinds of pressures on these neighborhood health centers, where they are getting squeezed in terms of the Medicaid population, they are getting squeezed in terms of the Medicare population, they have expanding responsibilities in terms of dealing with the AIDS population—both in terms of urban and now in rural communities—we have problems with teenage pregnancies, expansion of violence, expansion of TB in many communities—you have it in Harlem, you have it in parts of New Jersey and in part of my own State, as a result of homelessness.

So even if we try to get this thing right—and I know neither Senator Kassebaum nor I believe that if we get this thing right, our problems will be solved in terms of these underserved areas; that is clearly not the case—but we know that if we do not do this, we are taking a very, very important pillar away from beginning to resolve these problems. But what is happening? Are we drifting further, getting below the water level? It has always been up to about here in terms of surviving. Maybe you could just make a brief comment about the pressures that are out there, working in an opposite way from what we are trying to do here.

Dr. FILERMAN. Just a brief comment, Senator. Dr. Kindig mentioned the management issue. It seems to me that you are identifying a component of the system which cries out for entrepreneurial, creative, very strong management, because these organizations are more at risk than they have ever been in the past because of managed care moving in around them, among other things. And they have got to be competitive. They are not going to make it on the basis of a few Federal programs. They have got to be really full

community players. That takes a shift in attitude and a shift in management style because if it does not take place, a lot of them are going to go down the tubes.

Senator KENNEDY. Dr. Kindig.

Dr. KINDIG. I think those organizations doing the work they do, sponsored by this committee and others, are the reason why we have kept this chronic illness sort of barely under control. But I think you are right, the pressures are great. I am actually not necessarily as concerned as some others about the thrust of managed care. I think there are some creative things going on in neighborhood health center networks for people who actually have insurance, where that can actually help to structure the care and bring some efficiencies and provide a funding stream that is stable.

I think these neighborhood health centers, in addition to just the general issues of ambulatory reimbursement, which we all face—they really are where the uninsured go, and there is no managed care program that helps uninsured—so I think that that is another part of it.

I think they are doing a great job, and they are doing God's work, believe me, in these rural and inner city areas. People from NAC and other organizations can testify more eloquently than I. I think it is a critical Federal safety net until we deal with it, frankly, in a more general way.

Senator KENNEDY. Dr. Tuckson.

Dr. TUCKSON. Just very briefly, if you add up the equation that you just presented, it equals disaster, and that is exactly right. There is one other piece to it that you did not get to, and that is that as we, in our State and local communities, focus increasingly on crime, and as the criminal justice initiative takes ever more precedence over the health initiatives, we are watching the systematic destruction of the public health infrastructure in each of those communities. So that the natural allies that the community health centers are having to work with are also deteriorating.

So that what you now have are increasing levels of need, with extraordinary decreasing ability to meet it. When you add that up, it is a double disaster. And sir, I tell you, if you have the kind of vision that lets you see to the future, we are not prepared for it.

Senator KENNEDY. Thank you.

Thank you, Madam Chair.

The CHAIRMAN. Thank you very much.

Next I would like to say that Senator Frist, who has been quite an extraordinary specialist in his other life, is also I think at heart a generalist.

Senator Frist.

Senator FRIST. Thank you, Madam Chairman.

As a physician for the last 20 years of my life, I have been in a medical school every day up until about a year ago, when I started my campaign before coming to the U.S. Senate—literally, every day of my life at three medical schools, medical institutions. I have also had the privilege of spending the last 12 years in Nashville, TN, where I grew up, and I therefore want to share some of my reflections on Meharry and the particular role that it has played, that is not obvious unless you have observed or been a part of the evolving mission—the mission has been constant, but the evolving

carrying out of that mission and the changes it is undergoing every day.

Since 1989, Meharry and the dental schools have been identified as Minority Centers of Excellence, which we have begun talking about. The program was created and supported by this committee to recognize and reward institutions—one medical, one pharmaceutical, one dental, and one veterinarian—which were setting out to meet national goals, the national goals being to train minorities in the health professions, in improving services in underserved areas.

I am a specialist. The medical schools I have been at have been Harvard Medical School for 11 years, Vanderbilt for 12 years, and Stanford for 2 years. Those universities do not—do not—do a good job in either training minorities or serving underserved areas.

Meharry's mission very clearly has been to educate underrepresented minorities in the health professions while increasing the delivery of health care to these underserved communities. Clearly stated, and talking to the administrators and the needs, it is constant. That is the mission.

That mission was articulated long before the Federal Government expressed its interest; it really goes back to the 1860's when Meharry recognized it and has continued it. Not only has Meharry been meeting this goal ever since, but it really has been carrying the water for most other institutions.

Seventy-five percent of Meharry's graduates have started their practices in medically underserved inner city and rural areas. No other medical school can touch that statistic.

Yet when the GAO reviewed two studies to determine the extent of minority practice in underserved areas, it concluded that the sample pools—that is, from historically black colleges—may not be representative for all minority health professionals. I agree. They are doing a far better job in fulfilling that goal.

That leadership is why Congress chose to support them early on in recognizing their full potential.

COGME concluded that the racial-ethnic composition of the Nation's physicians does not reflect the general population, and we know that; we see that. I see it in my practice every day. This contributes to access problems for the underrepresented minorities. African Americans constitute about 12.1 percent of the population, but only 3 percent of physicians.

Both COGME and the American Association of Medical Colleges have called for a doubling of the enrollment of underrepresented minorities from the current approximately 1,450 to 3,000 by the year 2000.

Now, the other hat I currently wear is being a member of the Budget Committee, and I fully recognize the need that we have to focus our scarce Federal resources on programs that perform well in meeting our national goals, which have been clearly articulated. A Federal work force policy is important to the future success of our health care system. It may be on the back burner now, but it is going to reemerge shortly. The existing funding for the Minority Centers of Excellence I feel strongly has fulfilled and is fulfilling that goal.

By opening the pool of applicants, which we have touched upon today, it may follow that we make the resources that we have designated more scarce for these institutions. Congress in fact created many of our work force problems. And I think it is my responsibility, our responsibility, to very carefully look back upon the investments that we have made to make sure they are going into the correct areas to fulfill our goals.

We certainly should not risk undoing what has taken really 100 years to achieve. We certainly should not let politics enter into the equation to destroy the progress that has been made.

And I guess I have to express my feeling that even if these institutions can compete well—and I believe that they can—there are enough political pressures, subtle pressures, that will possibly prevent them from obtaining suitable significant funding to achieve their goals. I have a fear that competition is going to be more for winning the ear of the Secretary to talk about individual institutions, or politicians stepping up, trying to get something for their particular areas, that it is going to dilute the effect of the resources that we have been able to devote today.

I really feel that our best investment—and I say this having been at many medical schools and having spent my life there—is to reward those institutions that we know have done a good job, a better job than anybody else, in producing minority physicians.

Meharry Medical School has trained 40 percent of this country's black physicians—one institution. Meharry has trained 50 percent of all black dentists. The Federal funds over the last years—and they have been significant—have enabled Meharry to work toward financial stability and ultimately, financial independence. I have been back in Tennessee for about 12 years now, but I grew up there, so I have had the opportunity to see the impact that these funds have had toward achieving real financial independence.

Meharry very wisely, I feel, has invested these funds in faculty recruitment and retention—if you just look at the track record over the last 3 years, it is phenomenal. What has been accomplished is bringing people to Meharry to train physicians who are going to go out and serve underrepresented areas where people thought it simply was not possible.

Meharry schools have typically received funding—actually, all medical schools, as most of you know, receive funding from clinical practice, from research grants, some income from residency programs, State funds, local funds. Meharry simply has historically been unable to rely on many of these traditional funding resources. An example is in the clinical arena. Just recently, Meharry went through a merger with the General Hospital in Nashville—it is really currently underway—which for the first time is going to allow it to truly be able to recognize revenues from patients in its overall funding base. In the past, it simply has not been part of that base.

In addition, the recruitment of faculty, which has been so dramatic over the last several years, will allow it to increasingly be able to compete for research grants that in the past it simply was not able to do.

At GAO's recommendation, we are discussing outcomes evaluation of programs to better determine if the money coming from Fed-

eral programs is meeting national goals. I support that. I do want to make the statement that the Minority Centers of Excellence are not failing us. They are really leading us again, compared to the institutions that I have been at.

At the very least, I think we do need a very accurate evaluation process—and support that—before we consider shifting funds away from these institutions that we know have served this country so well. I really want to allow them, based on these evaluations, to prove that they are meeting our requirements.

I just simply think—and I am a new United States Senator, but I do not think we can articulate these great goals and simply fail to support them financially.

I have used my time, but I did want to make that statement based on my own personal experience as a physician. If there is one thing I hope to bring to this body as a citizen legislator, it is some practical experience from the field and have it reflected in this body.

With that, Madam Chair, I will forego any questions.

Thank you.

The CHAIRMAN. Thank you very much, Senator Frist, for a very good statement.

Senator Wellstone.

Senator WELLSTONE. I thank the chair.

Dr. Tuckson, it is good to see you again, and I apologize to each of you for being late. Today, Madam Chair, there were three committee hearings at the same time, so it is really frustrating.

First of all, Madam Chair, I would like to congratulate you for the work that you have done. I think that the efforts of the chair and Senator Kennedy in proposing some of the consolidations to make these very, very important programs work better and more efficiently, is right on the mark. I think it is very important.

I may not have any questions, and I do not have a long statement, but I will say that one of the things that has been resolved that I am much more comfortable with is that I am glad we are maintaining the scholarship program. I have to say that every time I hear discussion about how there is an oversupply of doctors, nurses and other health professionals, I always think, "What?" Of course, that is in relationship to demand as defined by the market, as defined by people who can demand it through their incomes. But in terms of inner city or rural America, that is not true at all. And I think we did not quite make it last time in terms of some major health care reform, but I think there was—maybe—some consensus on the importance of primary care and preventive health care and really delivering health care out in the communities where people live, in a humane and dignified and affordable way.

Madam Chair, the University of Minnesota-Duluth has just a fantastic program—I am so proud of what they have done—with Native Americans, in terms of the men and women who come from rural communities and then go back and practice in those communities. It seems to me that the principle here is that in terms of young people, "minorities," others from "disadvantaged backgrounds," I think it is extremely important that we keep the scholarship program, because that is what enables some of those men and women to come to the medical schools and other professional

schools and to go into these professions with a sort of connection to the communities from which they come and to go back to those communities and serve those communities. So I am just delighted that we have been able to keep the focus on that.

I do not really have a question, but I just wanted to make that clear. I thank each of you for your work, and it is good to see you again, Dr. Tuckson. And again, I apologize that I was not here earlier. I will read your testimony, I promise. I will be a good student, and I will read it—and probably the chair will give me an exam tomorrow morning to see whether I have read it.

The CHAIRMAN. Thank you, Senator Wellstone.

Senator Gorton.

Senator GORTON. No questions.

The CHAIRMAN. May I just come back with an observation, Dr. Filerman. I thought your comment on the importance of looking to the integrated services for the home was a very important comment. I think it is going to be more and more a direction for the future. I think we have to begin to plan now.

Dr. Tuckson has heard me at a previous meeting some years back mentioning how important I thought the old program of visiting nurses was in the homes, and I believe you said your mother had been a visiting nurse; is that right, Dr. Tuckson?

Dr. TUCKSON. Exactly right.

The CHAIRMAN. And I think we are seeing a return, maybe in a little different way, to wanting that strength of support from integrated health services in the home, which often establishes a very personal relationship that I think is very valuable.

So I would just say that I look forward to working with all three of you as we begin to think about this for the future.

Senator WELLSTONE. Ditto. I agree.

The CHAIRMAN. Thank you all very much. We appreciate your testimony.

It is a pleasure to welcome the next panel. I am going to take special privilege as the chair, because I am very proud of our dean of the University of Kansas School of Nursing. Dr. Eleanor Sullivan has provided tremendous leadership in the field of nursing, both as a national spokesperson, but certainly at the University of Kansas Medical Center as well. It is a pleasure to welcome you this morning. I should say that this morning, Dr. Sullivan is representing the American Association of Colleges of Nursing—I keep thinking just KU, but I know it is a larger umbrella than that.

Senator WELLSTONE. There are some other universities in the country, Madam Chair.

The CHAIRMAN. Yes, there are; I know. [Laughter.]

Next, it is a pleasure to welcome Allan Rosenfield. Dr. Rosenfield is dean of the School of Public Health at Columbia University and is here representing the Association of Schools of Public Health.

Next, Dr. Jordan Cohen is president of the Association of American Medical Colleges and is here representing that association today.

And finally, Dr. Larry Anderson, a member of the board of directors and chair of the Commission on Education, representing the American Academy of Family Physicians.

So if you would allow me, Dr. Anderson, we will start with Dr. Sullivan.

Dr. Sullivan.

STATEMENTS OF ELEANOR V. SULLIVAN, DEAN, UNIVERSITY OF KANSAS SCHOOL OF NURSING, ON BEHALF OF AMERICAN ASSOCIATION OF COLLEGES OF NURSING AND THE AMERICAN NURSES ASSOCIATION; DR. ALLAN ROSENFIELD, DEAN, SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY, ON BEHALF OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH; DR. JORDAN J. COHEN, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; AND DR. LARRY R. ANDERSON, MEMBER, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AND CHAIR, COMMISSION ON EDUCATION, ON BEHALF OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Ms. SULLIVAN. Thank you, Senator. And I will tell Senator Wellstone that I came from the University of Minnesota. That is where I learned all that I know.

Senator WELLSTONE. And that concludes your testimony?

Ms. SULLIVAN. No. [Laughter.]

As the Senator stated, I am Eleanor Sullivan, and I am dean of the School of Nursing at the University of Kansas, and I am presenting testimony on behalf of the American Association of Colleges of Nursing and the American Nurses Association. I have provided a complete copy of my testimony for the record.

We strongly support reauthorization of the NEA and the concepts of consolidation and flexibility that we understand will be elements of a bill to reauthorize it. We think that the real importance of this approach is to give flexibility to the nursing education community and to DHHS to address rapidly changing approaches to health care delivery and meeting public health needs.

That flexibility in essence trusts NEA managers and recipients to do the right thing, a step that is philosophically divergent from the prescriptive and micromanagement cast of past statutes. We support the concept of giving a priority to producing nurses to meet underserved population health care needs and holding grantees and DHHS accountable for meeting these objectives.

Providing one authorization figure for the whole NEA further expands the level of trust that the proposal bestows upon DHHS and continues to be a concern for us. We hope that the expansion of DHHS' authority this provision suggests will be tempered by giving the nursing education and practice community a significant role in determining NEA priorities.

For example, AACN's priorities are support for faculty education, advanced practice nurse programs and students, and community nursing centers for primary care training and faculty practice.

AACN continues to oppose State and local governments being included as "eligible entities." This is a nursing education statute, and AACN strongly believes that NEA money should go to educators and students. We remain concerned about the specifics and equities of matching requirements because most schools of nursing face their own financial difficulties. And with an aging population, more chronic disease survivors, and a growing interest in the pri-

mary care that nurses are capable of delivering, AACN regrets the proposal's need to reduce NEA authorizations in its later years.

We also suggest that the NEA bill be decoupled from the Title VII reauthorization bill to avoid delay in enacting a new Title VIII.

Now, some background. Serious shortages of hospital staff nurses inspired the passage of the Nurse Education Act 30 years ago. In fact, the Nurse Education Act helped me get my start in nursing 20 years ago, when I was a young widow with five small children, no money and no education. And I can assure you, Madam Chairman, that I would not be dean of the KU School of Nursing today without that help.

Since then, the NEA has helped to reverse much of that shortage by Federal program support for schools to increase the number of nurses with a basic education. Today, the NEA focuses on teaching advanced practice caregivers such as nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.

The NEA recognizes the importance of funding to prepare nursing faculty, to increase the racial and ethnic diversity of the nursing profession, and to maintain professional competence through continuing education. With funds for traineeship, the NEA helps masters and doctoral nursing students to become the advanced practice nurses of tomorrow.

There is a program to repay school loans for nurses who practice in an area with a nursing shortage, and the recirculating campus-based nursing student loan program offers low-interest loans to undergraduate and graduate nursing students and has an extremely low default rate.

I have a table of anticipated fiscal year95 awards for NEA programs that shows the number of nursing programs and students benefiting from this statute and request that it be included with my testimony. Each of these programs has contributed to nursing's growing role in improving the quality and effectiveness of America's health care delivery system.

In an ideal world, the system that utilizes these professionals would pay for their preparation; but in the real world, a combination of Federal and State support, together with student loans, money from parents or student employment, and other funds are the backbone of nursing education.

AACN and ANA believe that support for adapting nursing education to meet changes in health care delivery and public health needs in underserved areas is a Federal responsibility. The NEA also must facilitate improved racial and ethnic diversity in the nursing profession, and a new NEA should authorize funding at at least the same level as the fiscal year95 NA appropriations of $63.5 million.

We understand that one bill will be introduced with a Title VIII section for NEA and a Title VII section for other health professions education programs. We recommend that the NEA bill be separate, to avoid having the NEA reauthorization delayed by issues involved in the reauthorization of Title VII, which happened the last time the two were paired for reauthorization.

Also, we understand that the NEA provisions that will be in the forthcoming bill are virtually the same as those in S. 2433, the bi-

partisan bill that this committee and the Senate passed last year. We supported that bill.

Scholarships for Disadvantaged Students. This Title VII program, now at section 737 of the Public Health Service Act, is critically important to nursing students who now by statute receive 30 percent of its appropriations. SDS money for nursing amounted to $5.4 million in fiscal year 1995 and went primarily to undergraduate students. The past has taught nursing groups that due to organizational preferences or bias, nursing, with about 52 percent of all students in the health professions, will not get its fair share of this appropriation if it is merely one of the many health professions entitled to funding under a given statute. A fair distribution of these funds means that nursing students be allocated a specific portion of SDS or its replacement program moneys.

In conclusion, we support reauthorization of the NEA and the SDS, and I appreciate being given the opportunity to appear here today. I would be willing to answer any questions you have, Senator.

The CHAIRMAN. Thank you, Dr. Sullivan.

[The prepared statement of Ms. Sullivan follows:]

PREPARED STATEMENT OF ELEANOR SULLIVAN ON BEHALF OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING AND THE AMERICAN NURSES ASSOCIATION

Good morning Madam Chairman and members of the committee. I am Eleanor J. Sullivan, Ph.D., R.N., Dean of the School of Nursing at the University of Kansas, Kansas City, KS. I am presenting this testimony on behalf of the American Association of Colleges of Nursing which represents 466 senior college and university baccalaureate, master's and doctoral nursing education programs in public and private, large, medium and small institutions across the United States. My school is an AACN member. I am on AACN's Board of Directors and chair AACN's Governmental Affairs Committee. The American Nurses Association joins AACN in this testimony. The ANA is full service professional organization representing more than 205,000 nurses through 53 constituent and territorial associations. I am also an ANA member.

Reauthorization: AACN and ANA strongly support reauthorization of the NEA and the concepts of consolidation and flexibility that we understand will be elements of a bill to reauthorize the Nurse Education Act (Public Health Service Act Title VIII) that will be introduced shortly. We understand that one bill will be introduced with a Title VIII section for the NEA and a Title VII section for other health professions education programs. We recommend that the NEA bill be separate to avoid having the NEA reauthorization delayed by issues involved in the reauthorization of Title VII, which happened the last time the two were paired for reauthorization. Also, we understand that the NEA provisions that will be in the forthcoming bill are virtually the same as those in S. 2433, the bipartisan bill that this Committee and the Senate passed in the 103rd Congress. We supported that bill.

Background: Serious shortages of hospital staff nurses inspired passage of the Nurse Education Act 30 years ago. Since then the NEA has helped to reverse much of that shortage by federal program support for schools to increase the number of nurses with a basic education. Today, the NEA focuses on teaching advanced practice caregivers such as nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists. The NEA recognizes the importance of money for preparing nursing faculty, increasing the racial and ethnic diversity of the nursing profession, and maintaining professional competence through continuing education. With funds for traineeships, the NEA makes possible traineeships for Master's and doctoral nursing students to help them become the advanced practice nurses of tomorrow. There is a program to repay school loans for nurses who practice in an area with a nursing shortage. And the recirculating campus-based Nursing Student Loan Program (NSLP) offers low interest loans to undergraduate and graduate nursing students and has a low (2.51 percent in 1994) default rate. Each of these programs has contributed to nursing's growing role in improving the quality and effectiveness of America's health care delivery system. In an ideal world, the system that utilizes these nursing professionals would pay for their preparation; but in the real world,

a combination of federal and state support, together with student loans, money from parents or student employment and other funds is the backbone of nursing education.

AACN and ANA believes that support for adapting nursing education to meet changes in health care delivery and public health needs in underserved areas is a federal responsibility. The NEA of 1992 was seven individually authorized programs that somewhat limited federal support for the ability of the nursing education community and the Department of Health and Human Services to respond quickly to changes in public health system needs. We support a new NEA that gives the Department of Health and Human Services flexibility to redefine objectives based on the nursing professional needs of a rapidly evolving health care system. We think that provisions requiring grantee and DHHS accountability for meeting specific program goals are appropriate. The NEA must facilitate improved racial and ethnic diversity in the nursing profession. A new NEA should authorize funding at least at the same level as FY95 NEA appropriations ($63.5 million).

Current Nurse Supply: The total RN population of the United States in March 1992 was estimated at 2.2 million, 66.5 percent of whom worked in hospitals. ["1992 The Registered Nurse Population-Sample Survey," March 1992, p. 22; HRSA, PHS, DHHS]) The average age of the current nursing population also is rising (43.1 years old in 1992 (Sample Survey, p. 14).

Many nurses entering practice are older because they are second career people or have returned to work after raising families. AACN and ANA below discusses the importance of the NEA to graduate and to undergraduate nursing students and programs.

Graduate nursing students: These advanced practice nurses (APNs) will be the primary care deliverers and nursing school faculty of tomorrow. AACN's "Enrollment and Graduation Report," supra, shows 31,537 Master's students (most are part time) and 3,235 doctoral students (half are part time) (Table 6, p. 13) Of these Master's students 12,433 were nurse practitioner or nurse midwife students. (Table 24, p. 39) Of 7,116 Master's in Nursing graduates between August 1993 and July 1994, 2,298 were nurse practitioners or midwives. (Table 25, p. 40). The NEA can help graduate nursing education to reposition itself for managed care and an aging population and to continue the expansion of primary care functions and case management that are becoming the responsibility of advanced practice nurses who are so much in demand.

The 1992 NEA appropriately supplied program and individual support for graduate nurse education and students to address the strong demand for these versatile professionals. Particularly in rural or underserved areas, APNs provide much of the primary health care. Their education is shorter and less expensive than that of a primary care physician, yet they perform many of the same functions, as well as others that are the special province of nurses, with excellent outcomes and patient satisfaction and a tendency to use fewer expensive tests. Acute care APNs have begun to replace resident physicians.

What should the NEA do for APN education? The NEA should include programs to prepare these valued professionals and to provide individual traineeship support to help the students, now mostly part time, complete the programs more quickly. Incentives could encourage schools and students to focus on specific public health needs such as practice in underserved areas, primary care, pediatrics, gerontology, chronic disease, and case management. AACN agrees that DOS needs flexibility to work with the nursing education community on solutions to these and other public health problems.

Undergraduate students: AACN's recent "1994–95 Enrollment and Graduations Report" shows 133,464 baccalaureate students (Table 6, p. 13) (most are full time) and 35,217 baccalaureate graduates (Table 7, p. 14). As managed care sweeps the country, many hospitals are downsizing their staffs to reflect fewer occupied beds due to shorter stays and the growth of services delivered on an outpatient basis. Some staff nurses are among those who are losing their jobs. In an effort to push institutional costs down, some hospital managers are replacing RNs with unlicensed assistive personnel. A recent ANA study done by Lewin-VHI, Inc. on the effect of staffing patterns on acute care shows that strong nursing services increase the quality of patient care, benefit patient satisfaction, and reduce lengths of stay. We also know that graduates of baccalaureate nursing programs in some areas are taking a longer time to find jobs, and even then, may not obtain exactly the type ofjob they had hoped. Despite these conditions, there are a number of reasons why NEA support for undergraduate nursing students and programs is still needed. As that system evolves into a community based primary care model utilizing interdisciplinary teams of practitioners, undergraduate nursing education must be refocused. For ex-

ample, the system will need tertiary care nurses but also out-patient nurses for clinics and home care.

The 1992 NEA mostly focuses on graduate nursing programs but offers some support for the undergraduate sector. There is a small ($3.6 million) program to help disadvantaged students complete their nursing education by use of special mentoring and instruction. Much of the money in that Section 827 program went to schools that had a high proportion of minority students. AACN's "1994–95 Enrollment and Graduations report shows that 16.8 percent of undergraduate nursing students are minorities (Table 11, p. 18). This is a very good sign, but the same table shows that only 12.1 percent of Master's students and 10.3 percent of doctoral students are minorities. Looking at Table 13 (p. 20) in the same report, 14 percent baccalaureate, 11.1 percent Master's and 7.4 percent doctoral graduates are minorities. In the nursing profession, about 9 percent (Sample Survey, p. 13) are racial or ethnic minorities. AACN's and ANA's view is that this number could, and must, be increased as the U.S. population becomes more racially and ethnically diverse. AACN and ANA believe that the small amount of NEA money directed at helping disadvantaged students complete nursing education is necessary. Second, a sufficient cadre of undergraduate nurses must exist so that preparation to the advanced practice levels of nurse practitioners, midwives, anesthetists and clinical specialists can meet the strong demand for those professional. Third, the NEA's major role vis-a-vis undergraduates is the Nursing Student Loan Program which has such a low aggregate loan limit ($13,500) that the student usually hits the ceiling before his or her undergraduate education is complete. But NSLP is a campus based program that recirculates repaid funds and has not had a federal contribution in ten years. It also has a default rate of an impressively low 2.51 percent. Lastly, over the years the numbers of nurses have gone sharply up and sharply down, depending on what health workforce experts thought was needed. The result often was a nursing shortage. The role of nurses in the health care system is critical and growing and the system itself is changing how it uses various professionals, so even now it is not possible to say that we have enough nurses prepared at the basic level. With a growing older population and with more individuals with chronic conditions requiring case management and home and community based care, the United States will need more nurses. AACN and ANA urge the Committee to preserve the flexibility of DHHS to support undergraduate nursing students, particularly those from disadvantaged backgrounds. A mix of assistance for graduate and undergraduate programs and students will ensure the NEA's continuing relevance and federal presence in preparing nurses with a variety of skill, including those who seek to upgrade from Associate and Baccalaureate to Master's and doctoral degrees. Changes in the ways and places health care is delivered mean that nursing schools must revamp the education of the undergraduate nurse, and federal funds could help this process move more quickly.

Practicing nurse population: The NEA's role for practicing nurses should focus on the specific objectives of maintaining a high level of professional expertise and ensuring support for retraining where necessary. Federal support for continuing education is necessary in areas where geographic considerations present obstacles to nurses keeping up with scientific and practice developments. For example, continuing education funded by the NEA can help rural nurses maintain their competence where their local marketplace fails, or is unable, to do so. Another possible area for the NEA regarding practicing nurses is due to changes in the health care system. Practicing hospital staff nurses and even clinical nurse specialists with graduate degrees may need to be retrained to be able to continue to be productive as tertiary facilities are reduced, and primary care, home care and out patient care become prominent. We should make every effort to extend the productive services of these individuals by helping them acquire new skills. Retraining also might be a shared responsibility with the Department of Labor.

Administration Reauthorization proposal: From what AACN and ANA can infer from the Administration's FY 96 budget, its clusters approach will be similar to the NEA consolidation proposal put forth by the Administration in the 103rd Congress. That proposal was the basis for the Senate passed NEA reauthorization bill, S. 2433. AACN's concerns about S. 2433 were that:

—DHHS was given a great deal of discretion about where the funds would go without much guidance;

—matching funds could be required but few specifics were provided on how much of a match would apply or how DHHS would deal with schools that could not match;

—state and local governments, not just their academic institutions, were included as "eligible entities;"

—awards were limited to a maximum of 5 years, but there was no way to extend critical programs that would terminate without federal support, harming public health;

—the Basic Nursing Education section actually increased the number of possible topics for grants by adding a large number of new priorities; and

—the BNE also seemed directed toward service delivery rather than education.

AACN and ANA ultimately supported the bill because we decided that virtually anything that could have been done under the 1992 NEA could have been done under S. 2433. We were then, as now, curious about how compressing seven NEA sections into three and adding new foci would simplify the statute or save DHHS staff time in processing applications. The bill retained the separateness of the NEA from Title VII programs, a result that AACN strongly believes is compelled by the differences between nursing education and that of other health professions. Earlier this year, AACN made some suggestions to the Committee staff about clarifications needed in the report accompanying S. 2433.

The Kassebaum Consolidation bill: AACN has not seen the legislative language of Madam Chairman's proposal, but we can base initial comments on conceptual information supplied by Committee staff. We support the concept of consolidation of the NEA, and we think that the real importance of this approach is to give flexibility to the nursing education community and DHHIS to address rapidly changing approaches to health care delivery and meeting public health needs. That flexibility in essence trusts NEA managers and recipients to do the "right thing," a step philosophically divergent from the prescriptive and micromanagement of past statutes. But we think that it is worthwhile to give DHHS the discretion to address evolving concerns as they arise. Apparently, under the proposal each NEA program would have its own stated outcomes; this will work most effectively if grantees and DHHS jointly agree on what those outcomes should be. AACN continues to oppose state and local governments being included as eligible entities. (ANA takes no position on this issue.) This is a nursing education statute, and AACN strongly believes that NEA money should go to educators and students. We could see state and local governments hungry for dollars to pay for health care anxiously petitioning for NEA money to solve their problems, with education being a distant concern if it were addressed at all. We support the concept of giving a priority to producing nurses to meet underserved population health care needs. Providing one authorization figure for the whole NEA further expands the level of trust that the proposal bestows upon DHHS, and continues to be a concern for us. We hope that the expansion of DHHS authority this provision suggests will be tempered by giving the nursing education and practice community a significant role in determining NEA priorities. For example, AACN's priorities are support for faculty education, APN programs and students, and community nursing centers for primary care training and faculty practice. We remain concerned about the specifics and equities of matching requirements because most schools of nursing face their own financial difficulties. And with an aging population, more chronic disease survivors, and growing interest in the primary care nurses are capable of delivering, AACN regrets the proposal's need to reduce NEA authorizations in its later years.

AACN suggests amending the NEA to set the annual Nursing Student Loan Program loan limit at $4,000 per year and the lifetime aggregate at $20,000 or more. Current limits are an annual range of $2,500 to $4,000 and a lifetime cap of $13,500. By raising these limits, college and university financial aid officers will be able to make more effective use of the program. AACN also suggests that eligibility for NSLP loans be limited to students in their final two years of undergraduate study or to graduate study to ensure funding for those actually going into nursing. These NSLP changes will not affect federal program costs. And as we noted in the beginning of our testimony, we suggest that the NEA bill be decoupled from the Title VII reauthorization bill to avoid delay.

Scholarships for Disadvantaged Students: This Title VII program, now at Section 737 of the Public Health Service Act, is critically important to nursing students who now by statute receive 30 percent of its appropriations. SDS money for nursing amounted to $5.4 million in FY 95, and went primarily to undergraduate students. (This program replaced the Title VIII Scholarships for the Undergraduate Education of Professional Nurses (SUEPN) program that was repealed in 1992.) AACN had concerns about last year's reauthorization of this program by S. 1569 as a primary care program with a service payback in Health Professions Shortage Areas. The service payback would have been managed by the National Health Service Corps. Our concerns were that:

—The primary care focus seemed to be more directed at APNs because undergraduates are not trained as extensively in primary care as are, for example, nurse practitioners, yet it is undergraduate nursing students who are most in need of this

scholarship option (nurse practitioners and midwives have a 10 percent set-aside in the present NHSC scholarship program);

—NHSC has not previously placed entry level RNs and seems to have no clear ideas on how they would be utilized; and

—Requiring a service payback in an unknown HPSA years hence would be difficult to sell to many undergraduate nursing students, especially those who are disadvantaged and minority,who tend to want to practice near where they were educated.

AACN and ANA supported S. 1569 and its conference report, because, among other reasons, there was a specific set aside for nursing students. As we understand the concept of the Kassebaum "Consolidated Financial Assistance and Other Loan Programs," there would be one authorization for the group of health professions aid programs without any set-asides. The past—has taught nursing groups that due to organizational preferences or bias, nursing will not receive its fair share of appropriations if it is merely one of many health professions entitled to funding under a given statute. Because nursing has about 52 percent of all students in the health professions, fair distribution of these funds is critical. Until the NHSC was forced by legislation to use APNs, about 99.9 percent of its scholarship money went to physicians. AACN strongly urges that either a reauthorization of the SDS program include specific ending for nursing education or that the SUEPN program mentioned above, which was very successful, be reinstituted within the NEA. We ask the Committee to also consider our other concerns set forth above when reviewing this program.

CONCLUSION

AACN and ANA support reauthorization of the NEA and the SDS, and appreciate being given the opportunity to appear here today. I would be happy to answer your questions.

THE UNIVERSITY OF KANSAS MEDICAL CENTER
School of Medicine-Wichita, March 7, 1995.

Senator Nancy L. Kassebaum,
Chair, Committee on Labor and Human Resources,
United States Senate,
SH–835, Washington, DC.

DEAR SENATOR KASSEBAUM: I am writing to urge that, as you consider the reauthorization of health professions training programs under Title VII of the Public Health Service Act, you provide for continued support for training in the population-based health sciences ad public health. This matter is of great concern to me in my dual capacities as chair of the Department of Preventive Medicine here at the University of Kansas and as President of the Association of Teachers of Preventive Medicine (ATPM). The views of ATPM are discussed more fully in a statement submitted for the record of the March 8, 1995 hearing on health professions education programs jointly by ATPM ad the America College of Preventive Medicine. I respectfully request that this letter also be made part of that record.

The core of preventive medicine is that it brings the medical/scientific model of practice to populations. Just as primary care clinicians provide integrated services over time to individuals, preventive medicine physicians continuously monitor the health of defined populations, evaluate the rise to the health of that population, and intervene to address those rise. The tools of preventive medicine are skills in research design, data analysis, the translation of quantitative findings into specific interventions, and program evaluation. These skills, the population-based health sciences, are taught, both in medical school departments such as ours ad in schools of public health.

Fully integrated health care delivery systems, the model toward which our country is moving, should meld both the individual perspective of the clinician and the community health perspective of preventive medicine and public health. Knowledge about the community's health status and health needs is essential information for individual health care. Successful disease prevention and health promotion particularly require coordinated interventions at both the clinical and community levels. The synergy between individual and community health will be attained only when it-is understood and valued by all health care professionals.

I believe it essential, therefore, that the population-based health sciences receive support comparable to that provided for clinical training. They should be an integral aspect of training and practice of all health professionals who provide primary care or who contribute to primary care systems. In order to accomplish this, we need a well-trained cadre of professionals devoted to preventive medicine and public health practice, teaching and research. Support for faculty and curriculum development, as

well as for student stipends, in departments of preventive medicine, preventive medicine residencies, ad schools of public health would fulfill this function. This support, long provided for clinical medical specialties through Medicare graduate medical education funding, has never been available to preventive medicine and public health. Now, with a rapidly evolving health system that demands attention to health outcomes and quality improvement, the population-based health sciences should be more fully integrated into the mainstream of both undergraduate and graduate medical education. Title VII provisions that explicitly support preventive medicine and public health training alongside training in clinical disciplines is a logical and reasonable way to promote this.

Here in Kansas we are hoping to initiate a large and innovative primary care physician education program heavily supported by the Kansas Health Foundation and the State. This initiative will attempt to educate a large new cadre of physicians to practice community oriented primary care in Kansas. Our Department of Family ad Community Medicine in Wichita has benefited significantly under Title VII of the Public Health Service Act. We are hopeful that preventive medicine funding can be expanded under this reauthorization. All of our primary care departments will need this type of support in order to sustain our exciting primary care physician education initiative.

Thank you very much for your consideration and for your thoughtful leadership in prevention and health professions education.

Sincerely,

S. EDWARDS DISMUKE, M.D., M.S.P.H
Professor and Chair,
Department of Preventive Medicine.

The CHAIRMAN. Dr. Rosenfield.

Dr. ROSENFIELD. Madam Chairman, members of the committee, it is a pleasure to be here. I am Allan Rosenfield, dean of the Columbia School of Public Health, an obstetrician-gynecologist, and president-elect of the Association of Schools of Public Health, on whose behalf I appear.

I should note, Madam Chair, that there are three schools in Massachusetts and one excellent school in Minnesota, and we need one in Kansas.

My colleagues and I appreciate the opportunity to testify on the contributions of academic public health in promoting health and preventing disease in the Nation in general, and to justify continued Federal support to the 27 U.S. schools of public health in particular.

In its landmark 1988 study entitled, "The Future of Public Health," the Institute of Medicine stated boldly that "this Nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray. The current State of our abilities for effective public health action is cause for national concern and for the development of a plan of action for needed improvements."

An earlier IOM study presented evidence that the majority of preventable deaths in our society are related to public health issues such as the prevention of substance abuse, better nutrition, exercise, and a variety of population-based initiatives. And yet only a tiny percentage, and a truly tiny percentage, of the some $1 trillion health budget is devoted to public health.

Madam Chairman, your bill addresses many of the concerns outlined by the IOM. The deans of schools of public health stand ready to assist in efforts to ensure its enactment.

Today, schools of public health are looking to the future health needs of our communities. Faculty are working on projects such as AIDS prevention and control, identifying with a host of newly-recognized risks such as hazardous waste, indoor air pollution, vio-

lence prevention, problems of health care services for inner city and rural poor, not to mention providing our students with the needed knowledge, skills and competencies to function effectively under the reformed managed care system that we are developing, including, as stated earlier by Dr. Lee and others, better data collection and better management of the data, outcomes measures, and quality of care assessment.

Managed care and proposed block grants, or decentralization of funding programs to States and local governments, will require the deployment of professionals with a broad range of skills such as those obtained in the educational programs of the 27 schools.

The Federal Government has been a partner in this combined national effort to ensure that our Nation's public health system is staffed by competent personnel. However, the Public Health Service has estimated that only one-third of the public health work force has had graduate training in this field.

We as a nation would not allow this to be the case in any other health profession such as medicine, nursing or dentistry. Imagine, for example, if only a third of the doctors in this country were trained in medical schools.

Madam Chair, we commend your forward-thinking views and thoughtful approach to the reauthorization of health professions education and training in the United States. Given the patchwork of 42 separate work force development programs currently administered by the Public Health Service, your proposed bill establishes a platform for further deliberations that are starting today at this important hearing.

In general, we endorse your health professions education consolidation legislation proposal; however, we have particular suggestions that we believe merit your consideration.

First, we enthusiastically support the primary goals of the bill—to improve the distribution of health professionals in underserved areas, and to enhance "the production and distribution of public health personnel to improve the State and local public health infrastructure."

The legislative proposal in our opinion provides much-needed authorization and appropriations to support the former; however, a specific title for public health is requested to complement the primary care training in the bill. We recommend that schools of public health and other public health programs be made eligible to compete for training funds under the proposed authority. Currently, schools of public health are eligible to compete under peer review for public health special projects to address the rapidly deteriorating infrastructure in our country.

Madam Chair, the Federal contribution to public health education in the last decade can be termed as "decimal dust" when compared to the $6 billion contributed annually to graduate medical education. At best, Congress has appropriated less than $10 million a year to public health and preventive medicine training—a truly minuscule amount of funding.

A specific public health training authority in your bill, Madam Chair, would send a clear signal that Congress is willing to begin addressing the current public health infrastructure crisis.

Before commenting on other titles of the bill, we would like to highly commend you for the further development of preventive medicine residency programs in schools of public health and in medical schools.

Again, we would like to commend you for proposing the consolidation of the various authorities for minority and disadvantaged students in the schools of the health professions. Allowing the HHS Secretary discretion to fund projects based on need makes sense. Giving the Secretary authority to consolidate current earmarked funds into one general authority will, in our opinion, encourage the application of multidisciplinary approaches to the current status of seriously inadequate minority representation in the health professions, as has been discussed.

However, we are concerned that the bill requires disadvantaged students to serve in underserved areas only. Awards should be based on need and should not steer scholarship students in only one direction.

We also endorse, Madam Chair, the approach outlined in the "health professions work force development" title of your bill. Again, giving the Secretary the discretion to fund projects that seek to improve the delivery of health services in underserved areas, as well as to address the need for health professionals in short supply, is a sound way to invest scarce Federal resources. There is a shortage, Madam Chair, of public health professions in the U.S. today, especially in areas such as epidemiology, biostatistics, several environmental and occupational health specialties, MCH, management and policy sciences, public health nursing and nutrition, and physicians trained in public health and preventive medicine. This authority will help address this lack.

We would like to add our support to the approach taken in the "consolidated financial assistance" title of the proposal, especially the authorization expanding the National Health Service Corps to include public health graduates in the program. We have been requesting this change for some time. It represents initial steps required for the establishment of a complementary National Public Health Service Corps that would provide public health agencies and community-based organizations with a cadre of new professionals equipped with the needed skills and competencies to function effectively under a reformed system. We also request that public health students be eligible to apply for health professions student loans.

Madam Chair and members of the committee, on behalf of the 27 deans of the schools of public health, we appreciate the opportunity to express our views on continued Federal support of the health professions education in general and for public health professions in particular. Your thoughtful consideration of the suggestions outlined in my testimony today and in the extended remarks you have received would be greatly appreciated.

I shall be pleased to answer any questions you might have.

Thank you.

The CHAIRMAN. Thank you, Dr. Rosenfield. Everyone's full statements, of course, will be made a part of the record.

[The prepared statement of Dr. Rosenfield follows:]

PREPARED STATEMENT OF DR. ALLAN ROSENFIELD

Madam Chairman and members of the committee, I am Allan Rosenfield, dean of the School of Public Health at Columbia University and president-elect of the Association of Schools of Public Health on whose behalf I appear today. My colleagues and I appreciate the opportunity to testify on the contributions of academic public health in promoting health and preventing disease in this nation, in general and to justify continued federal support to the 27 U.S. schools of public health, in particular.

In its landmark study entitled The Future of Public Health (1988), the Institute of Medicine (IOM) stated boldly that "this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray—the current state of our abilities for effective public health action—is cause for national concern and for the development of a plan of action for needed improvements.

Madam Chairman, your bill, "The Health Professions Education Consolidation and Reauthorization Act of 1995" addresses many of the concerns outlined by the Institute of Medicine. The deans of the schools of public health stand ready to assist in efforts to ensure its enactment.

The 27 schools of public health in 19 states and Puerto Rico constitute a primary source of comprehensively-trained public health professionals to serve the federal government, the 50 states and the private sector. To meet the inevitably growing demands for leaders who can recognize and work toward viable solutions to the nation's multiple health care problems, these schools must be funded to support costs in three main areas. First, it is crucial to assist students in financial need, so that highly motivated and qualified students will not be turned away. Second, we want to be able to strengthen and expand our educational programs in areas urgently calling for prevention and control, including, but not limited to:

—HIV/AIDS
—substance abuse
—violence and injuries
—teenage pregnancy
—the poor health problems of women and children
—the health problems of the elderly
—access to health care
—envivronmental and occupational health hazards

The third area of funding is aimed at forging a cooperative link-up between faculty and students on the one hand, and operational public health agencies and community-based organizations on the other.

In 1956, the 84th Congress passed the Public Health Service Act in a unanimous vote to support professional education in public health. Since then, bipartisan support has repeatedly extended these programs in public health.

The rationale for the legislation was based upon the recognition by Congress that preservation of the public's health requires more than merely reacting to disease, illness and disability. Indeed, it was felt that perhaps a better, more rational and economic approach would be a judicious combination of disease prevention and health promotion, along with improved planning and organization of therapeutic and rehabilitation services.

The public health workforce is the most diverse and multidisciplinary of all of the health professions. According to the U.S. Public Health Service (PHS), it is comprised of approximately 3 million workers including representatives of such medical and social science professions as physicians, nurses, dentists, administrators, epidemiologists, environmental health specialists, nutritionists, biostatisticians, psychologists, behavioral scientists, lawyers, chemists and engineers.

The need for trained public health professionals could double the current level, according to a recent PHS report to Congress. The need has intensified with the proliferation of health programs mandated by Congress, not to mention new and expanded responsibilities of health organizations under managed-care. According to the PHS, there are currently shortages of epidemiologists, biostaticians, environmental health specialists, public health nurses and physicians, among others. In addition, the IOM maintains that "most public health workers, including some public health leaders, have not had formal educational preparation focused on public health."

In our judgment, the nation's schools of public health are unique and vital elements of a system needed to prepare the personnel required to make population-based approaches to health promotion and disease prevention successful. The need to recognize and solve the health problems, which occur in a group and community environment, requires education by a faculty consisting of professionals skilled in various disciplines including social and natural sciences, environmental sciences,

measurement sciences, and administrative management, to pinpoint the very complex health problems of our multi-faceted communities. Together, they are stronger in arriving at creative solutions than any single discipline or profession alone.

It is important to realize that the schools of public health have already made contributions out of all proportion to the total federal investment in their activities. American schools of public health are one of our greatest national resources. The faculty and research staffs of these schools have made unparalleled contributions to improving the health of people throughout the world. I would like to just mention a few contributions:

—the development of the iron lung, along with research that led to the eradication of polio in the Americas

—playing a critical role in the complete eradication (for the first time in history) of a worldwide public health scourge-smallpox

—the discovery of Vitamin D; and re-discovery of Vitamin A to prevent blindness

—the development of a Hepatitis B vaccine

—the development of strategies to eradicate hookworm and other infections, including sexually transmitted diseases; schools have also provided important insights into the prevention of typhus, trachoma, malaria, and numerous other diseases.

—the development of DRGs and RVSs under Medicare

Today, schools of public health are looking to the future health needs of our communities. Faculty are working on projects such as AIDS prevention and control, and on identifying and dealing with a host of newly recognized risks such as hazardous waste and indoor air pollution, violence prevention, among others, not to mention providing students with the needed knowledge, skills and competencies to function effectively under a reformed, managed-care system.

Managed-care and proposed block grants, or decentralization of funding programs to states and local governments, will require the deployment of professionals with skills in:

—community health education
—chronic and infectious disease prevention
—health care economics and cost analysis
—outcomes analysis
—regulation assessment
—policy making and analysis
—coalition building, public communication, and training
—principles of managed care and cost containment

Providing these competencies, Madam Chairman, is what the 27 schools of public health are all about. The federal government has been partner in this combined, national effort to ensure that our nation's public health system is staffed by competent personnel. However, the PHS has estimated that only one-third of the public health workforce has had graduate training in the field. We, as a nation, would not allow this to be the case in other health profession, such as medicine, nursing, or dentistry. Imagine if only one-third of the doctors in this country were trained in medical schools; what would the state of health care be if only one third of the nurses were trained in nursing schools?

We have no scientific studies to accurately establish the precise national shortages of public health professionals. According to the PHS, the supply of public health professionals is impossible to estimate accurately, due in part to some disagreement over which occupations compose public health and the lack of specific licensure requirements. Therefore, estimating supply, is limited to the opinions of experts in the field. However, experts agree that there is a shortage of adequately trained, public health professionals, especially in expanding fields such as environmental health, managed-care, new infectious diseases, violence prevention, among others.

Madam Chairman, we commend your forward thinking views and thoughtful approach to the reauthorization of health professions education and training in this country. Given the patchwork of 42 separate workforce development programs currently administered by the Public Health Service, your proposed bill establishes a platform for further deliberations that started today at this important hearing. In general, we endorse your health professions education consolidation legislative proposal; however, we have particular suggestions that merit your thoughtful consideration.

First, we enthusiastically support the primary goals of the bill: improve the distribution of health professionals in underserved areas, and enhance "the production and distribution of public health personnel to improve the state and local public health infrastructure." The legislative proposal, in our opinion, provides much needed authorizations for appropriations to support the former; however, a specific title for public health is requested to complement primary care training in the bill. We

recommend that schools of public health be made eligible to compete for training funds under the proposed authority. Currently, schools of public health are eligible to compete (under peer review) for public health special projects (Sec. 762) to address the rapidly deteriorating infrastructure.

Madam Chairman, the federal contribution to professional public health education in the last decade can be termed as "decimal dust" when compared to the $6 billion contributed annually to graduate medical education. At best, Congress has appropriated less than $10 million a year to public health and preventive medicine training. Yet this "decimal dust" has partially financed the education and training of many of our nation's public health leaders, most of whom work in the public health sector, and has enabled our faculty to assist local agencies in solving public health problems with special projects grants.

Special public health funding has been critically important at my own school of public health. Such funds have initiated a program for minority and disadvantaged students to ensure their support throughout their tenure at the school and to facilitate placement in many medically underserved areas nationwide. Special project support has been utilized over the past four years to nurture an effective and growing collaboration between the School of Public Health and the New York City Department of Health. Special project support has been utilized to bring faculty at the school and public health practitioners together to focus on improving the Public health delivery infrastructure throughout the city and the nation by:

—identifying young children at risk for learning disabilities

—developing strategic public health plans to meet the most urgent public health needs in metropolitan areas, designing a special approach to improve access to immunization in inner city communities

—developing a drug-resistant TB registry in New York (which has in many respects, been a model for the nation)

—developing an improved system for tracking TB patients to ensure completion of directly observed therapy

In addition to these important projects, current special project funding facilitates critical continuing education for public health practitioners in New York, the development of a broad range of violence prevention activities, and innovations in cost-effective distance learning approaches both for continuing and degree education. Without special project support,the urgent need to bridge schools of public health and local and state health departments—one of the primary recommendations of the Institute of Medicine's report, The Future of Public Health—will be severely undermined.

A specific public health training authority in your bill, Madam Chairman, would send a clear signal that Congress is willing to begin addressing the current public health infrastructure crisis.

Before commenting on other titles of the health professions reauthorization bill, we would like to highly commend you for the further development of preventive medicine residency (PMRs) programs in school of public health, as well as in medical schools.

The need for physicians trained in preventive medicine has been consistently documented. However, our current system of financing graduate medical education has provided only minimal support of this training, because most preventive medicine residency programs are not based in hospitals. Reform and innovation in both public health and private financing of grate medical education in preventive medicine is necessary to address this shortage and to realize fully the potential of preventive medicine to help build a healthier nation. Until Congress amends Medicare to allow for PMRs support, your bill, Madam Chairman, recognizes the important contributions of preventive medicine physicians in managing the quality and costs of health services for populations served by health agencies and managed care organizations.

Again, we would like to commend you for proposing the consolidation of the various authorities for minority and disadvantaged students in the schools of the health professions. Allowing the HHS Secretary discretion to fund projects based on need makes sense; giving the Secretary authority to consolidate current earmarked funds into one general authority will, in our opinion, encourage the application of multidisciplinary approaches to the current status of deplorable minority representation in the health professions. However, we are concerned that the bill requires disadvantaged students to service in underserved areas. Awards should be based on need; and should not steer scholarship students into service commitments.

These multidisciplinary and interdisciplinary themes are further underscored in the "community-based training in underserved areas" title of the bill. We support these approaches as well as language that gives preference to the training of students that will enter practice in underserved areas.

We also endorse, Madam Chairman, the approach outlined in the "health professions workforce development" title of the bill. Again, giving the Secretary discretion to fund projects that seek to improve the delivery of health service in underserved areas, as well as to address the need for health professionals in short supply, is a sound way to invest scarce federal resources. There is a shortage, Madam Chairman, of public health professionals in the United States today, especially in the following areas: epidemiology, biostatistics, several environmental and occupational health specialties, public health nutrition, public health nursing, and physicians trained in public and preventive medicine. This authority will help address the lack of trained professionals in these fields.

In closing, we would like to add our support to the approach taken in the "consolidated financial assistance" title of the proposal, especially the authorization expanding the National Health Service Corps to include public health graduates in the program. We've been requesting this change for quite some time now, Madam Chairman. It represents initial steps required for the establishment of a complimentary National Public Health Service Corps that would provide public health agencies and community-based organizations with a cadre of new professionals" equipped with needed knowledge, skills and competencies to function effectively under a reformed system.

Under our proposal, persons choosing to enter the NPHSC would undergo rigorous training in schools of public health and would receive an MPH after instruction and education in the population-based sciences. Graduates, in exchange for federal support of their graduate public health education, would agree to commit one or more years of service in official state/local public health agencies and community-based organizations. Schools/programs would receive federal assistance for faculty and curriculum development as well as support to develop programs that establish working relationships (training sites) with state/local health agencies and community-based organizations, including managed care organizations.

In summary, Madam Chairman, there is an urgent need for trained public health professionals throughout the health system, including many in public and private non-profit agencies and institutions that are not directly engaged in the provision of hands-on care for the ill, but do impact on the availability, quality and cost of medical care, and on health services generally, including disease prevention, health promotion, and protection of the public from hazards to health (radiation, toxic substances, air and water pollution, etc.). Past federal support helped establish programs that effect constructive change by widening the perspectives and increasing the management capabilities of senior and mid-level professionals in community health centers, hospitals, state and local health departments, managed-care organizations, environmental agencies, among others.

The federal funds received by schools of public health have been considered to be the federal government's share of preparing public health personnel to meet the needs of the public today and for the future. The amounts, while small in comparison to overall expenditures, have and continue to contribute to the preparation of this vital health resource.We believe that the proposed "Health Professions Education Consolidation and Reauthorization Act of 1995" continues this tradition.

Madam Chairman and members of the committee, the 27 deans of the U.S. schools of public health appreciate the opportunity to express our views on continued federal support of health professions education, in general, and for public health professions, in particular. Your thoughtful consideration of our suggestions outlined in my testimony today would be greatly appreciated.

I shall be pleased to answer any questions you might have. Thank you.

The CHAIRMAN. Dr. Cohen.

Dr. COHEN. Madam Chairman, let me start with the pattern set by my colleagues and let you know that I am a native of Kansas City; my mother still receives her care from doctors and nurses trained at KU, so I feel a linkage.

I am pleased to be here, Madam Chairman. I am Jordan J. Cohen, president of the Association of American Medical Colleges, an association that represents the Nation's medical schools, major teaching hospitals, and medical students and residents in training. I appreciate very much the opportunity to be here before you today. I have submitted a written statement for the record, and I will summarize only briefly the points in that statement.

The Association supports your overall approach toward reauthorization of Titles VII and VIII, Madam Chairman. We have a few concerns that I will address before concluding my statement today.

Academic medicine clearly has an obligation to graduate physicians educated and qualified to promote the health of the public. To this end, the Association and its member institutions have embarked recently on two major initiatives that correspond with the goals of Title VII—the Association's Project 3000 by 2000, which Dr. Frist has already alluded to, and its Generalist Physician Task Force.

Project 3000 by 2000 was launched by the Association in 1991 to help remedy the underrepresentation of minorities in U.S. medical schools and in the physician work force. The project was created to double the number of underrepresented minority students entering medical school each year, by the year 2000, to the level of 3,000 matriculants that year and thereafter.

Through establishing a national network of community partnerships with colleges and local school systems, we are confident that we can increase dramatically the number of young minority students who eventually become successful applicants to medical schools and other health sciences programs.

Medical schools are responding positively to the Project 3000 by 2000 challenge. Since 1991, the number of underrepresented minority students entering first-year medical school classes has increased by 27 percent, putting us right on target for achieving our goal by the year 2000.

On the issue of primary care, the committee is well aware of the downward trend over the past three decades in the number of practicing generalist physicians as a fraction of the total physician work force. To help reverse this alarming decline, early in 1992, the Association appointed a Generalist Physician Task Force charged with developing a policy statement for the Association and with recommending an action agenda to promote generalism.

Our efforts, which are discussed more fully in my written statement, are beginning to produce very positive results. Graduates selecting residency programs in family practice, general internal medicine, and general pediatrics rose in 1994 for the second straight year, and now stands at 22.8 percent of graduating seniors, an increase of more than 8 percentage points in the brief span of 2 years.

I just might add that next week, the match results for this current class of graduating seniors will be announced, and we are informed that there will be another significant increase in the number of our graduating seniors who are electing careers in these generalist fields.

Madam Chairman, the Association supports the general tenor of your reauthorization proposal. However, I would like to highlight a few particular concerns and suggestions we have for the proposal as you have outlined it.

First, the Association would like to see the creation of an avenue through which the health professions community can collaborate with the Federal Government in determining how best to allocate the limited resources available within Title VII and VIII program clusters.

Second, we believe preferences for issuing Title VII and VIII grants and contracts should recognize the need not only to reward institutions that have already been successful, but should as well support institutions and programs that have made a commitment to address the problems of supply and distribution within the health work force, but still need assistance in fulfilling those objectives.

Third, we hope your legislation will encourage cooperation between the generalist specialties and will incorporate preferences that do not place any of the three generalist specialties—that is, general internal medicine, general pediatrics, and family practice—at an inherent disadvantage one with the other.

Fourth, the Association continues to oppose attaching service commitments to Title VII need-based scholarship programs. We believe students from disadvantaged backgrounds should not be deprived of an opportunity to make an informed and mature career decision based on their particular talents and aspirations just because they need scholarship assistance. All fields of medicine require the attributes of the minority community to enlarge their agendas.

Finally, I would like to touch on the proposed reauthorization of the Council on Graduate Medical Education, or COGME. The Association strongly supports the existence of a national mechanism for monitoring physician supply by specialty and by geographic location and is eager to cooperate with appropriate efforts to refine the signals being sent about future work force needs to participants in the health care marketplace. Although the COGME represents an extremely useful start along the right path, the Association has some concerns about the organizational structure of the council and the level of support provided to it.

Notwithstanding these points, Madam Chair, the Association is supportive of the overall thrust of your proposal and looks forward to working with members of this committee in reauthorizing Titles VII and VIII and resolving our few points of concern.

I thank you for the opportunity to testify and for your leadership on this issue, and I would be pleased to answer any questions you or the committee might have.

The CHAIRMAN. Thank you, Dr. Cohen.

[The prepared statement of Dr. Cohen follows:]

PREPARED STATEMENT OF DR. JORDAN J. COHEN

Good morning, Chairwoman Kassebaum and Members of the Committee. Thank you for inviting me to present the views of the Association of American Medical Colleges as you consider reauthorization of Titles VII and VIII of the Public Health Service Act. I am Jordan J. Cohen, M.D., president of the AAMC, which represents the 126 accredited United States medical schools, nearly 400 major teaching hospitals, over 90 academic and professional societies, and the nation's medical students and residents in training.

The Association commends you, Senator Kassebaum, for holding this hearing on the reauthorization of Titles VII and VIII. As you know, Titles VII and VIII of the Public Health Service Act authorize the only federal programs specifically designed to assist health professions institutions and programs in three key areas:

—promoting the education of generalist physicians and other essential health professionals,

—enhancing the supply of these health professionals in rural and medically underserved areas, and

—contributing to diversity in the health workforce by increasing the representation of minorities and individuals from disadvantaged backgrounds in the health professions.

As we in the health professions community strive to accomplish these missions, Titles VII and VIII can continue to offer the critical support our community needs to fulfill its social responsibilities. The Association supports your overall approach toward reauthorization of these important programs, Senator, but we have a few concerns which I will address before concluding my statement today.

Academic medicine has a clear obligation to graduate physicians educated and qualified to promote the health of the public, a goal embodied in the Title VII legislation. To this end, the Association of American Medical Colleges and its member institutions have embarked recently on two major initiatives, both of which are already beginning to show positive results. These projects are the Association's Project 3000 by 2000 and its Generalist Physician Task Force.

Project 3000 by 2000 was launched by the Association in 1991 to remedy the underrepresentation of blacks, American Indians, Mexican-Americans, and mainland Puerto Ricans in U.S. medical schools and the physician workforce. The goal of Project 3000 by 2000 is to increase the number of underrepresented minority students entering medical school each year to 3,000 by the year 2000, a doubling of the number of minority matriculants over the course of the decade. Under the banner of this initiative, the AAMC has set out to create a national network of community partnerships comprising schools of medicine, affiliated teaching hospitals, other health professions institutions, colleges, and elementary and secondary school systems. We are confident that this network will dramatically increase the number of young minority students who eventually become successful applicants to medical schools and other health science programs.

Medical schools are responding positively to the Project 3000 by 2000 challenge. By 1994, the third year of the program, over half of all U.S. medical schools reported that they had comprehensive Project 3000 by 2000 implementation strategies in place. Since 1991, the number of underrepresented minority students entering first-year medical school classes has increased 27 percent, from 1,584 to 2,014 students. This increase puts us right on target for achieving our ambitious goal, and we are convinced we can do it with everyone's help. I have attached the Project 3000 by 2000 Year Three Progress Report for the record as Appendix A.

In addition to recognizing minority underrepresentation in the health professions, this Committee is also well aware of the downward trend over the past three decades in the numbers of practicing generalist physicians. During the 1980s, the declining interest of medical students' in pursuing careers in family medicine, general internal medicine, and general pediatrics was especially pronounced. The percentage of graduating senior medical students planning certification in the generalist specialties fell from 34.1 percent in 1983 to a low of 14.6 percent in 1992.

To reverse this alarming decline, early in 1992 the Association appointed a Generalist Physician Task Force charged with developing a policy statement for the Association and with recommending an action agenda to promote generalism. The AAMC formally adopted a policy position in October 1992 advocating an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine, or general pediatrics) and that appropriate efforts be made by all schools to meet this goal within the shortest possible time. The Generalist Physician Task Force also set forth a variety of recommended strategies for promoting generalism aimed at schools of medicine, graduate medical education, the practice environment, and the Association itself. I have attached the AAMC Policy on the Generalist Physician for the record as Appendix B.

In response to the Task Force's recommendations, the Association established the Office of Generalist Physician Programs to lead our nationwide effort to assist the medical education community in achieving this objective. The Office serves as a resource to AAMC member institutions by providing information about institutional generalist initiatives, model programs, and federal and state policies. The Office also coordinated the first-ever National Primary Care Day on September 29, 1994, a nationwide event co-sponsored with nine medical student organizations. On National Primary Care Day, medical schools across the country held day-long programs highlighting careers in primary care to spark the interest of medical students in generalist medicine.

Our efforts to promote generalism have already produced results and will enable us to build on the recent upswing in graduating medical students' interest in the generalist specialties. Graduates' selection of residency programs in family practice, general internal medicine, and general pediatrics rose in 1994 for the second

straight year, and now stands at 22.8 percent of graduating seniors, an increase of more than 8 percentage points since 1992.

Recognizing the importance of Title VII to medical students and the efforts of medical educators, the Task Force also recommended that the AAMC continue its advocacy for adequate funding for Title VII programs. The Association's Project 3000 by 2000 and generalist physician initiatives are among the many endeavors of academic medicine that have been supported in part by Title VII funding. My colleagues on this panel and I are certain that the problems of supply, distribution, and minority underrepresentation in the current health workforce would been even greater than they are today were it not for the support offered by Titles VII and VIII.

The successes fostered by Titles VII and VIII are noteworthy. For instance, the number of medical schools with clinical departments of family medicine grew from fewer than 10 in 1970 to nearly 80 by 1977, a growth that can be attributed in large part to Title VII grants authorized in 1972 for the creation of family-medicine departments. From 1972 through 1977, the federal investment in these grants totalled just $13 million. Currently, 106 of the 124 accredited four-year medical schools have departments of family medicine.

Title VII continues to play a major role in the undergraduate and graduate medical education of today's generalists. For instance, Title VII grants have supported a 25-percent increase in the number of divisions of general pediatrics within academic departments of pediatrics over the last ten years. In addition, Title VII has supported the development of 31 new general internal medicine residency programs since 1990, an increase of 26 percent over four years. The net result of these programs has been a virtual transformation in the opportunities available to medical students interested in pursuing generalist careers.

The Area Health Education Centers (AHEC) program is another Title VII success story. Established in 1972, the AHEC program extends federal support to schools of medicine for the formation of partnerships between health sciences centers and health care delivery systems in medically underserved communities. Most AHEC programs sponsor multiple centers throughout a region or state that promote health improvement and disease prevention and deliver primary health care services to local communities. At the same time, these AHECs provide health professions institutions with sites for collaborative, interdisciplinary, community-based educational experiences for health professionals, students, and residents. More than 1.5 million health professional students have trained at AHEC sites during the program's 23 years of existence.

After an initial period of federal support, AHEC projects are expected to continue operating using state, institutional, and other non-federal assistance. In 1993, 37 AHEC programs were active in a national network crossing 35 states. These programs are able to continue and to flourish by leveraging federal funds; they have succeeded in attracting four dollars in state and local matching funds for every dollar of federal investment.

The Title VII Area Health Education Centers program clearly exemplifies the synergies possible in well-crafted federal-state and public-private partnerships. In my view, medical schools have done an outstanding job of operating AHEC programs, and we look forward to continuing these collaborations with federal and state government. As you consider reauthorization of Titles VII and VIII, we hope you will maintain this successful arrangement in its present form.

Madam Chairwoman, the AAMC supports the general tenor of the reauthorization proposal you have outlined. Your proposal would instill flexibility in the capacity of the federal government and the health professions community to address public health needs. Moreover, the proposal would simplify the processes of grant application and issuance and enable the federal government to administer the Titles VII and VIII programs with greater efficiency.

Your proposal would consolidate the more than 30 categorical Titles VII and VIII programs into six new authorities:

—primary care and preventive medicine training,
—minority and disadvantaged training,
—community-based training in underserved areas,
—consolidated financial assistance and other loan programs,
—nursing workforce development, and
—health professions workforce development.

By eliminating many of the prescriptive limitations in the various categorical grant programs, the proposal should enhance the ability of health professions institutions and programs to design new and innovative programs that correspond to the health needs of the public. In addition, the emphasis on outcomes evaluation should help ensure that programs operate in accordance with national and local priorities

and that the federal government is receiving a proper return on its investments. We hope the legislation will direct the Health Resources and Services Administration, which oversees the Titles VII and VIII programs, to provide proper guidelines and support for institutions and programs in the evaluation process.

Although the Association supports the Chairwoman's efforts and leadership, we do have some concerns with the proposal as currently outlined. First, the Association believes the health professions community can contribute constructively to the setting of national workforce priorities. Although the proposal would maintain the participation of individuals from outside the federal government in the review of individual grant applications, the proposal does not offer health professions associations, institutions, or programs the opportunity to participate in decisions about what types of initiatives should be supported and at what levels within each cluster. We support providing the health professions community with an avenue to collaborate with the federal government in determining how best to allocate the limited resources available under Titles VII and VIII.

The proposal also confers funding preference in some program clusters upon applicants who, for instance, have successfully placed a high percentage of graduates in primary care practice or in medically underserved areas. These institutions and programs should be rewarded for and encouraged to continue their efforts. However, we believe Titles VII and VIII can and should be a mechanism to foster change. To achieve this end, Titles VII and VIII grants and contracts should also be made available to those institutions and programs that have made a commitment to address the problems of supply and distribution within the health workforce and need assistance in fulfilling their objectives.

We are pleased that your proposal recognizes the importance of all three generalist medical specialties—family medicine, general internal medicine, and general pediatrics—in the provision of primary health care. We hope the legislation will encourage cooperation, rather than competition, between the generalist specialties. In particular, we urge you to design preferences for awarding grants to generalist residency programs and administrative units that do not place any of the three generalist specialists at an inherent disadvantage.

The Association is also concerned by the proposal to consolidate the three Title VII scholarship programs for disadvantaged minority and financially needy students (the Exceptional Financial Need scholarship, Financial Assistance for Disadvantaged Health Professions Students scholarship, and Scholarships for Disadvantaged Students programs) into one scholarship program that requires recipients to enter into commitments similar to those required by the National Health Service Corps. Although we have strongly supported the National Health Service Corps since its inception, we continue to oppose attaching any service commitments to the Title VII need-based scholarship programs. Awards based on need should provide access to health professions education to students from economically and educationally disadvantaged backgrounds, not direct these students into particular careers or areas.

The AAMC and its member institutions continue to oppose strongly any legislation that requires disadvantaged students to make a premature commitment to a medical specialty to qualify for need-based student financial assistance. We believe students from minority or disadvantaged backgrounds should not be deprived of an opportunity to make an informed and mature career decision based on their particular talents and aspirations just because they need scholarship assistance. The Association fears that many well-intentioned matriculants will enroll in service-connected scholarship programs to receive this important financial aid, only to find later that their aptitudes are better suited to another area of medicine.

Although the Association and its member institutions acknowledge the need to produce more generalist physicians, we are also dedicated to fulfilling our mission to educate more physicians from disadvantaged backgrounds, especially underrepresented minorities, in all of the medical specialties. Virtually every minority population in this country is underrepresented in each facet of medicine, including research and teaching. By channeling disadvantaged minority students into the primary-care specialties, the proposal risks exacerbating the shortages of minority physicians in other areas where their talents are sorely needed as well.

Notwithstanding our particular concerns, the Association remains supportive of the overall thrust of this proposal. We look forward to working with the members of this Committee in reauthorizing Titles VII and VIII, and hope to have the opportunity to discuss with you further the few points of concern I have raised. Thank you again for the opportunity to testify and for your leadership on this issue, Madam Chairwoman. I would be pleased to answer any of the committee's questions.

The CHAIRMAN. You may not realize it, but now there is a true, genuine Kansan sitting on your right. Dr. Anderson is a family physician from Wellington, KS, and while Dr. Sullivan is a transplanted Kansan, Dr. Anderson grew up there and has provided extraordinary leadership in the medical community, not only Wellington, but in Kansas.

Dr. Anderson, welcome again.

Dr. ANDERSON. Thank you, Senator, and other members of the committee.

The CHAIRMAN. I do not want you to think I have stacked this committee testimony, though. [Laughter.]

Dr. ANDERSON. Well, we know that Kansas is the center of the universe.

My name is Larry Anderson, and I am a rural family physician from Wellington, here today representing the 80,000 members of the American Academy of Family Physicians. I am delighted to have this opportunity to speak about an issue of critical importance to our organization and to the health care of your constituents—reauthorization of Title VII of the Public Health Service Act.

Before I go further, however, let me commend Chairperson Kassebaum for her work on legislation to reauthorize this important law.

This country suffers from a severe shortage of family physicians and other primary care doctors. This shortage has existed for decades, and it is growing worse. For example, our Nation now has 2,492 federally-designated primary care health professions shortage areas. This is a 30 percent increase in the last 8 years, despite a simultaneous increase in the total number of physicians.

My personal experience is that of a county well-served by 19 physicians when I started practice in 1976, but now critically underserved, with only nine physicians remaining to care for a population of 29,000.

Physician overspecialization is a large factor in our Nation's health system problems. All nations which provide current universal access to health care use systems which are based on at least 50 percent primary care physicians. Our work force is made up of more than 70 percent subspecialists, with only 30 percent in primary care and only 13 percent total in family practice/general practice. This country will never have full access to quality health care with predictable costs, including Government health cost, until the shortage of primary care physicians is resolved.

Despite this Nation's need for family physicians, the market demand outstrips our capacity to train them. Members of this committee need to know that the marketplace, which is clamoring for family doctors, has little or no influence over the medical schools and teaching hospitals that train physicians because there is no meaningful connection. Federal dollars allow many of these training institutions to remain aloof to the growing needs of society.

Medicare support of graduate medical education and research funding provided by NIH are heavily biased toward the production of subspecialty physicians and inpatient care. The May 1994 GAO report states that "barriers to primary care training persist in Medicare's payment method." Again, "barriers to primary care training persist in Medicare's payment method."

In sharp contrast, however, to Medicare GME stands Title VII. Section 747 of that Act is the only Federal program that provides targeted funding for family practice.

The Federal investment in family physician training has paid off handsomely. Family physicians are trained in ambulatory settings, are more cost-effective, are distributed in urban and rural areas in the same proportion as the U.S. population as a whole, take up practice in direct primary patient care and are able to handle 85 to 90 percent of all their patients' problems.

The Academy has had the opportunity to review the draft legislation on health professions. We believe that the bill will improve the supply of primary care physicians, meet health care needs in underserved communities, and streamline and consolidate Federal programs.

We strongly support the provisions in the legislation making grants and contracts to develop, operate, expand or improve departments of family medicine in medical schools. Title VII grants for establishing departments of family medicine have resulted in seven new departments in the past 3 years. The October 1994 GAO report indicated that "students who attended schools with family practice departments were 57 percent more likely to pursue primary care."

Title VII also encourages medical schools to create required third-year clerkships in family medicine, and we strongly support this required third-year training experience.

As 15 of our 126 medical schools still lack departments of family medicine, and 51 do not have required third-year clerkships, you can see there is still much left to do.

Many family practice residencies would not be in existence if it were not for Title VII support. Continued funding will be needed to promote the continued growth of quality residency programs and to build the infrastructure needed to identify and train family practice faculty to fill the 600 currently vacant academic positions.

The Academy is enthusiastic about the addition of preferences for project grants based on outcomes criteria that include an increased output of primary care providers and individuals who actually enter practice in underserved communities. We strongly support targeting of scarce Federal resources on areas of greatest need, specifically, primary care and services to the underserved.

Title VII of the Public Health Service Act provides the foundation for a program that successfully produces family physicians who serve both rural and urban populations with quality, cost-effective health care. As you critically review Government programs for their cost-effectiveness and overall value, Title VII is a program that scores high on both fronts because it works.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Anderson follows:]

PREPARED STATEMENT OF DR. BARRY R. ANDERSON

My name is Barry R. Anderson, MD, and I am a practicing family physician from Wellington, KS. It is my privilege to serve on the Board of Directors of the American Academy of Family Physicians and as chair of the Academy's Commission on Education. On behalf of the Academy's 80,000 members, I am delighted to speak with you this morning about an issue of critical importance to our organization and to the health care of your constituents, reauthorization of Title VII of the Public

Health Service Act. Before I begin my testimony, let me commend Chairperson Kassebaum for her work on legislation to reauthorize this important law. We deeply appreciate your interest and look forward to continued collaborative efforts. My testimony will discuss the importance of Title VII, as well as describe how successful this program has been.

FAMILY PRACTICE TRAINING

By whatever measure you might employ, this country suffers from a severe shortage of family physicians and other primary care doctors. The shortage of primary care physicians has existed for decades, and it is growing steadily worse.

For example, since 1986 the number of federally designated primary care health professions shortage areas has increased from 1,949 to 2,492, and the number of primary care physicians needed to eliminate these shortages has grown from 4,314 to 4,677. This has occurred despite a large increase in the overall number of physicians. My personal experience is that of a county well-served by 19 physicians when I started practice in 1976, but now critically underserving a population of 29,000.

Among community health centers, which rely heavily on primary care physicians, 52 percent report difficulty recruiting physicians. And, managed care organizations, which are mostly urban based and aggressively recruit family physicians, 43 percent of salaried and 29 percent of capitated plans report that it takes almost one year to recruit a new primary care physician.

Of additional concern is that the U.S. population 65 years of age and older will rise about 2 percent per year between now and the year 2020. These individuals will require a wide range of health care services, including preventive, primary, long-term, rehabilitative and hospice care. Delivering these services will require a substantial increase in the number of family physicians.

The shortage of family physicians is not due to an inadequate number of physicians, but, rather, to the overspecialization of the American physician workforce. Overspecialization is a large contributor to our nation's health care problems. Any attempt to control costs and maintain quality in the American health care system will be frustrated by the shortage of primary care physicians. While in most countries at least 50 percent of physicians are in primary care (family physicians, general internists and general pediatricians), the U.S. physician workforce is made up of more than 70 percent subspecialists and only 30 percent primary care physicians. Family physicians/general practitioners make up only 13 percent of the total. The Physician Payment Review Commission, Council on Graduate Medical Education, American Medical Association and Association of American Medical Colleges all advocate increasing the supply of generalist physicians. We will never improve access and get health care costs under control, including government health care costs, until the shortage of primary care physicians is addressed.

The most compelling evidence for the shortage of family physicians is not so much in the findings of expert panels as in the marketplace itself. Primary care is the marketplace's answer to our nation's cost, quality, and access problems. The demand for family physicians in the market overwhelms our ability to train family physicians. Family practice residents receive typically hundreds of unsolicited job offers. Yet, the gap between supply and demand grows steadily. We are unable to see further improvements in the efficiency of health care delivery because this nation's primary care capacity is so underdeveloped.

It is essential for the members of this committee to recognize that the "marketplace," which is clamoring for family physicians has little or no influence over the medical schools and teaching hospitals that train physicians. Our academic medical centers have remained largely unresponsive to the shortage of family physicians because there is no meaningful connection between them and the market for health care services. Federal government support allows most of these training institutions to remain aloof to the growing needs of society.

Medicare's support of graduate medical education and extramural research funding provided by the National Institutes of Health are heavily biased toward the production of subspecialty physicians and inpatient care. Over $6 billion in Medicare GME payments go exclusively to hospitals, where subspecialist physicians receive most of their training, rather than to ambulatory care sites, such as clinics and offices, where family physicians receive much of their training. This continues to occur despite the fact that more and more and more care is delivered outside the hospital. A May, 1994 General Accounting Office (GAO) report reiterated that "barriers to primary care training persist in Medicare's payment method."

In sharp contrast to Medicare GME stands Title VII of the Public Health Service Act. Section 747 of that Act is the only federal program that provides targeted funding through grants for residency training, establishing and maintaining depart-

ments of family medicine, predoctoral programs, and faculty development. Section 747 is currently authored at $54 million and received an appropriation of $47 million in FY 1995. Many family practice residency programs would not exist today if it were not for the availability of the Title VII funds. Until Medicare GME funding changes occur, family practice residency programs and medical school departments of family medicine will remain highly dependent on grants from Title VII.

DATA AND OUTCOMES THAT PROVE TITLE VII WORKS

The federal investment in family physician training has paid off handsomely. Family physicians are trained in ambulatory settings and go on to provide ambulatory care, which is the type of care that people need most. Studies show that generalist physicians are more cost-effective due to their prudent use of hospital services, tests and procedures. Furthermore, family physicians are distributed in urban and rural areas in the same proportion as the U.S. population as a whole—unlike any other physician specialty. Also unlike any other specialty, virtually all physicians who complete family practice residency tag take up practice in direct primary patient care and are able to handle 85–90 percent of their patients' problems.

Title VII has improved the supply of primary care physicians in several important ways.

FAMILY MEDICINE DEPARTMENTS

Title VII grants for establishing departments of family medicine in medical schools have resulted in seven new departments in the past three years. An October, 1994 GAO report indicated that "students who attended schools with family practice departments were 57 percent more likely to pursue primary care." The same report indicated that "students attending medical schools with more highly funded family practice departments were 18 percent more likely to pursue primary care." However, fifteen of the nation's 126 medical schools still do not have departments of family medicine. Title VII dollars are crucial to establishing these family practice departments.

PREDOCTORAL PROGRAMS

Funding for predoctoral programs—third-year medical school clerkships in which students learn primary care clinical skills—under Title VII encourages medical schools to create required third-year clerkships in family medicine. Requiring a third-year clerkship of more than four weeks duration results in 15.6 percent of a school's graduates choosing careers in family practice, compared to 6.9 percent of the graduates of schools without required third-year clerkships. Moreover, the October, 1994 GAO report indicated that "students who attended schools requiring a third-year family practice clerkship were 18 percent more likely to pursue primary care." However, fifty-one of the nation's 126 medical schools still do not have required third-year clerkships in family medicine. Because so many medical schools still do not have required third-clerkships in family medicine, establishing required clerkships in all medical schools is the single, most effective action that can be taken to increase the number of graduates entering primary care careers.

FACULTY DEVELOPMENT

Faculty development funding under Title VII is essential to address a severe shortage of faculty for family practice residency programs and medical school departments of family medicine. The success of family practice residencies in placing graduates in primary care practice settings has had the unintended consequence of creating a shortage of family practice faculty. There are nearly 600 vacancies at present. Seventy percent of residency programs have at least one faculty position unfilled. Currently 18 residency program director positions are vacant and another eight are anticipated in the next two years. In addition, approximately 20 to 30 department chair positions are vacant. Faculty development funding must be expanded to meet training needs as they currently exist.

DRAFT LEGISLATION ON HEALTH PROFESSIONS

The Academy has had the opportunity to review the draft legislation on health professions. We believe that Chairperson Kassebaum's bill will make a substantial contribution toward meeting the nation's need for primary care physicians. The primary purposes of the legislation are to improve the supply of primary care physicians, to meet health care needs in underserved communities, and to streamline and consolidate federal programs. We strongly support the bill's increased flexibility and

the explicit targeting of scarce federal resources on areas of greatest need, specifically primary care and services to the underserved.

As you know, the legislation is divided into seven sections: primary care and preventive medicine training; minority and disadvantaged training; community-based training in underserved areas; consolidated student assistance; nursing workforce development; other priority health professions training projects; and a variety of other provisions from last year's Minority Health Improvement Act Conference Report.

As a general comment, the Academy is particularly enthusiastic about the inclusion of preferences for project grants based on outcomes criteria that include an increased output of primary care providers and individuals who actually enter practice in underserved communities. To the extent that limited federal funding is available to commit to these educational initiatives, these criteria are not only appropriate, they are essential to ensure that the overarching federal policy objectives are met. The General Accounting Office has noted that absent information about the actual output of these programs, it has been impossible to evaluate program success, much less to enforce accountability relative to program goals. In addition, the Academy supports the increased flexibility built into the proposed legislation. We believe it important for the Secretary to be able to target scarce federal resources on areas of greatest need.

REQUIREMENTS IN THE DRAFT LEGISLATION ON PRIMARY CARE

family medicine departments and residency programs

Of particular interest to family practice under the legislation are the provisions making grants and contracts to "develop, operate, expand, or improve" departments or academic administrative units of family medicine, general internal medicine, and general pediatrics. As noted above, grants for establishing departments of family medicine in medical schools have resulted in seven new departments in the past three years.

The Academy supports the funding preferences in the bill for programs with the "highest percentage of providers that enter primary care practice on the completion of training," and for "programs which successfully produce professionals who go on to provide service in underserved areas."

faculty development

In terms of faculty development under the legislation, the Secretary is given the authority to determine the projects to fund based on "national and state workforce goals." As noted above, there is a severe shortage of family medicine faculty. The Academy supports this provision.

third-year clerkships

Regarding "Medical School Primary Care Training," these activities would be funded through departments of family medicine and other primary care specialties. This would include "required undergraduate community-based medical student clerkships in family medicine, internal medicine, and pediatrics." Because of the linkage between required third-year clerkship and a school's graduates choosing family practice careers, the Academy strongly supports this provision.

REQUIREMENTS IN THE DRAFT LEGISLATION FOR COMMUNITY-BASED TRAINING

The proposal calls for the consolidation of four existing program authorities into a new Community-Based Training program. The programs to be consolidated include Area Health Education Centers, Health Education and Training Centers, Geriatric Education Centers, and Rural Interdisciplinary Training grants. The Community-based Training program appears to most closely resemble the existing AHEC authority, with a few important modifications.

Currently, Area Health Education Centers are established through cooperative agreements between the Public Health Service and academic health centers. Area Health Education Centers (AHECs) are designed to assist health professional schools to improve the distribution, supply, quality, utilization, and efficiency of health personnel in shortage areas through the efficient use of regional educational resources. The program assists schools in planning, developing, and operating area health education centers. Through these AHECs, academic resources are linked with local resources to establish networks of health-related institutions that provide educational services to students, faculty, and practitioners. The program has proved its success in encouraging student interest in primary care, supporting primary care residency programs, and assisting rural physicians in meeting their continuing medical education needs. As a result of these activities, the AHEC program appears to have been largely successful in increasing the supply of primary care physicians in counties where their sites are located.

Based on this track record, the Academy continues to strongly support the fundamental structure and objectives of the AHEC program and believes these should figure prominently in federal strategies to improve the supply of health care personnel in rural areas. Under the Chairwoman's proposal, the kinds of entities eligible to receive these consolidated community-based thing grants would be expanded beyond medical schools to include state and local governments, health professions schools and other public and non-profit entities. The Academy supports the rationale behind this expansion—namely, that it could leverage greater support for these initiatives and assure greater coordination of similar programs throughout a political jurisdiction. We would encourage the Committee to make this rationale explicit in the legislation by requiring issues of support and coordination to be addressed in grant applications.

REQUIREMENTS IN THE DRAFT LEGISLATION FOR CONSOLIDATED STUDENT ASSISTANCE

Under the section on Consolidated Financial Assistance, which combines most of the current scholarship and loan repayment programs into the present National Health Service Corps Scholarship and Loan repayment, the Academy supports its emphasis on requiring service in underserved areas in return for assistance because the Corps relies heavily on primary care physicians. As a general matter, the Academy finds low repayments to be a much more effective means of encouraging primary care careers and practice in underserved communities. Scholarships are awarded prior to the time that medical students can be expected to make a final career choice. As a result, too many scholarship recipients either default on their service obligation or enter subspecialties, the need for which is extremely limited.

CONCLUSION

Title VII of the Public Health Service Act is a program that successfully produces family physicians who serve both urban and rural parts of our nation, are preferentially recruited by managed care organizations, and who can take care of 85–90 percent of their patients' problems. Numerous organizations and reports point out the cost-effective nature of family physicians, as well as how family practice residency programs, departments, predoctoral programs and faculty development programs efficiently produce more family physicians—meeting the primary care workforce needs for this country.

At a time when policymakers are critically reviewing government programs for their cost effectiveness and overall value, Title VII is a program that scores high on both fronts; it works. This committee's continued support of family practice training will facilitate a more efficient health care market. We applaud Chairperson Kassebaum's desire to reauthorize this important program, and her strong focus on primary care and the needs of underserved communities.

The CHAIRMAN. Thank you, Dr. Anderson.

Because you are a family physician, have you noticed that managed care is making a difference in particularly family practice physician care? Is there any trend that one is able to observe with the managed care?

Dr. ANDERSON. Certainly there is a trend in managed care. I think we need to reflect on the fact that what we had before—traditional fee-for-service indemnity insurance—was a good plan, but it did not work. The incentives are against the kinds of services that most of our populations need, so we have drifted away from primary care, as you well know.

Managed care is just another idea—the new idea—of how to provide health care for all of our citizens, and it may be the plan that is here 25 years from now—it probably will be. But prepaid insurance changes how we think about taking care of patients. We do not think about what we do to them; we think about keeping them healthy and well.

It is a great idea, and no other country really has it, other than Great Britain, which has somewhat of a capitated system for the primary care doctors. But certainly managed care is as a sponge, taking many of our young graduates. It is difficult to get doctors

to come to where I am to practice, although I do have a fairly large amount of my practice that has become managed care. So that yes, managed care is a very definite driving factor, and it does impact family doctors.

Dr. COHEN. Another way, Senator, that the managed care industry is impacted is, of course, as was just mentioned, in the marketplace. The demand for family physicians and other generalist physicians now is much greater than it had been. Salaries are starting to be increased; starting stipends for newly-trained generalist physicians in the managed care organizations are becoming more competitive than they were in the fee-for-service arrangement. So that that signal is beginning to be heard in the medical schools and in our residency programs, and I think in all honesty probably accounts for a good part of the upturn in the interest that is being expressed now by graduating seniors from medical schools. They know that there are now job opportunities at more attractive financial arrangements than had been the case heretofore, and I think that is accounting for some of the increased interest.

The CHAIRMAN. I think you all heard Senator Hatfield's comments on the area health education centers, or area health centers. How advantageous do you think that is? Are you supportive of a move in that direction again, in attempting to bring together a far more integrated delivery system that combines private and public health? Could you speak to that, please?

Dr. COHEN. Yes, I am personally—and I think I speak for the Association—supportive of efforts to expand the concept that is embedded in area health education centers. I think they have been very successful in bringing service to outlying areas, as well as combining the training and the opportunities for training in a team concept that is devoted to a patient-oriented population-based kind of education. I think the medical schools have been very successful in organizing those activities. Academic medical centers have been, as you know, the engines that have driven those AHECs, and I think they have been extraordinarily successful and certainly deserve to be expanded.

The CHAIRMAN. Dr. Rosenfield.

Dr. ROSENFIELD. Two brief comments. One, I agree completely. I think the AHEC experience has been a very positive one, and they deserve continued and expanded support.

A comment on managed care. I think managed care is the engine that is running through the country very rapidly. It was more active on the West Coast in the past, and it is now spreading rapidly on the East Coast. But one problem that we have to keep in mind that is not perhaps part of this bill directly is the uninsured population, which is increasing and not being covered by managed care or by the other activities. And they are in the inner cities, and they are among the working poor of our country; they are not the poorest of the poor. We believe now that that figure may well be up to 40 million people, that it increased some million people in the last year. And the managed care movement is not taking part in helping to solve that particular problem, which I think is one of our country's greatest public health crises.

The CHAIRMAN. Would you say—and I do not want to get too far afield from this bill——

Dr. ROSENFIELD. I understand that.

The CHAIRMAN. I agree with you, and of course, many States are wanting to move Medicaid into the managed care concept.

Dr. ROSENFIELD. In my State, as you know, the new Governor has stated that within a year—which we think is much too fast—to try to have 100 percent of Medicaid patients covered by a managed care system. That still does not take account of, in New York City, in New York State, the large numbers of people who are——

The CHAIRMAN. Who are not covered by Medicaid. That is right.

Dr. COHEN. If I could just add another comment, another issue that is closer to the concerns of this bill, Madam Chairman, is the issue of education, which managed care also is not taking responsibility for.

The ability of academic health centers to use clinical revenues to support initiatives in education and expanding ambulatory care education and other kinds of initiatives is rapidly disappearing as we see the managed care market closing down on the revenues that academic health centers have depended upon. So that means that these kinds of sources of support in your bill are ever more important.

The CHAIRMAN. My time is about to run out, and I want to ask Dr. Sullivan some questions on nursing, because we have had some discussions in previous panels about this. Given some of the comments about where there are shortages, and that the nursing supply seems to be in flux, and that there is probably an adequate supply of registered nurses, but perhaps nurse practitioners or the advanced degree nurses are in shorter supply, do you agree with that?

Ms. SULLIVAN. Yes, I think it is true, Senator, that that is where our most desperate need lies. But Senator Wellstone mentioned earlier that part of the supply and demand issue really has to do with what the marketplace, determined by the people who at that moment in time want to hire nurses, controls. And we have found that that system is not always adequate. In times of tremendous shortage of registered nurses, we have found that that resulted from a time when the marketplace sort of shrunk down in preparation for what they thought was going to be an oversupply and then turned out not to be, and enrollments decreased in schools of nursing.

So there are still desperate needs. At Hays Medical Center in Hays, KS, the director of nursing told me just a few weeks ago that she was desperate for registered nurses, and particularly people with baccalaureate degrees. I think that is another issue that Dr. Lee brought up earlier, that he thought that the higher-level training, as compared to maybe an associate degree, was so needed, and especially for the home care kind of care that you were talking about earlier.

The CHAIRMAN. Do you feel that with the flux in the nursing situation and the work force that it is good to give the administration greater flexibility in the funding?

Ms. SULLIVAN. Basically, I do. I think that that way, the administration can move wherever the priority is and respond more rapidly than having the specific priorities before.

I do remain somewhat concerned that the nursing community, the practice community and the education community, be involved in helping to form those decisions.

The CHAIRMAN. That goes back to several comments that have come through other panels, I think, about what kind of input the Secretary will have. I think Dr. Filerman suggested national board. Of course, there is COGME, which does have the statistics and data and input, and one of the reasons why I think it has been hard to structure a national board is who sits on the national board. But it seems to me that it is very important, as we move in some very new directions, to be able to understand that and the effects of these new directions—just as you mentioned, Hays needs nurses, but Topeka may not. I mean, within our own States, there are such differences, and perhaps a lack of data to analyze that as we attempt to put it into the larger picture.

So I would welcome some advice on this, because we have been struggling with what might be a good idea as far as putting that together.

Thank you very much. My time is up.

Senator Wellstone.

Senator WELLSTONE. Thank you, Madam Chair.

I have a set of specific questions, and I do not want to get too far off the mark of this legislation, but in the context of the discussion of managed care, managed competition, I was interested in your responses, Dr. Anderson and Dr. Rosenfield.

I do not want to put words in the mouths of other people, but I must say that in Minnesota, when it comes to a lot of the nurses and a lot of the family doctors, it is sort of less than universal approval of the direction in which medicine is going. Once upon a time, it seems to me, these managed care plans were very staff- and consumer-driven, but now, the trend is toward mergers and mergers, and it is becoming a very corporatized, bureaucratized kind of medicine.

No conspiracy argument intended, but I think the seven largest insurance companies now own and control about 60 percent of the managed care plans—and fee-for-service has its problems, especially its deemphasis on preventive care, but then the other problem is that with set premiums, the incentive for managed care is to underserve, because that is how you make your profit.

There has been too much gatekeeping, and I am very concerned about the direction here. I have been shocked—and I am not trying to be melodramatic—at the extent of demoralization of the caregivers. I do not think demoralized caregivers are good caregivers, and I think that is a reality in this country. And I am not going to be "Mr. Self-Promotion," but I am going to introduce a bill next week which tries to build in a lot of due process for consumers and caregivers vis-a-vis this sort of consolidation.

And I really think, Madam Chair, that when it comes to where the poor fit in—and Dr. Rosenfield, I think you were trying to allude to this—basically, in terms of where these plans locate, and whom they are interested in—we all know who costs the most money to serve. So that without some accountability built into this system, older people and poorer people and people who are sicker

because they are poorer and are poorer because they are sicker, have not fit in very well. So I just wanted to lay that out.

A couple of questions—and I think maybe some of you want to respond to that, and if you do, fine—I will just list two questions and then open it up for whomever wants to respond.

One is this whole question of the private sector, as long as we are talking about managed competition and managed care plans. I am wondering what their role should be in supporting some of these programs, minority programs, preventive health care programs, because in a sense with the teaching hospitals, you cannot cost-shift any longer, and this is the squeeze. And yet it seems to me there may be a role for the private sector. I wonder whether any of you would be interested in responding to that.

And on nursing, two questions. I think, Dr. Sullivan, you did respond to the chair's question about whether there is an undersupply or an oversupply of nurses. I wanted to ask about the need for advanced practice nurses, and specifically in what kinds of locations, where you see that fitting into the delivery force.

I am also interested in what you think the record of the Nursing Education Act programs has been, especially in meeting the needs in rural and underserved areas. And then finally, I would be interested in any recommendation you might give as to what percentage of the scholarship funds should go to nurses, and what would be fair in terms of allocation.

Anyway, my overall comment about my concerns about corporatized, bureaucratized, bottom line medicine and the demoralization of the caregivers—which I think is a story that needs to be told—whether you see that or feel that, and then some specific more focused questions.

Any of the panelists, please.

Dr. COHEN. I will begin, Senator. I think you have put your finger on an extremely important issue, and I appreciate your sensitivity to it, because I do think there is a lot of demoralization in the practicing community and certainly in the academic community, which is wrapped up now in the real world of practice, and are suffering many of the dislocations that you made reference to. So I do think it is an issue that needs to be attended to, and I do think we have to recognize the way in which this rapid transformation has some significant advantages in terms of cost-effectiveness and in terms of integrated care and less fragmentation of care and all. But I think there are some real down sides that need to be addressed.

On the issue of the role of the private sector and supporting the kinds of issues that are in this bill, Secretary Lee made a comment earlier, before you arrived, in response to the issue of what is the role of the Federal Government, and he pointed out that there are social goods that simply are not addressed by the marketplace. And I think we are talking about here, both in terms of indigent care, but also in terms of training issue and minority access and other things that are addressed in these titles, that these are social goods that do need to have broad-based societal support if we are going to address them.

I think it would be wonderful if we could find a device for spreading the responsibility across the private sector and encourage pri-

vate sector incentives to participate; but absent a comprehensive approach to the health care system, it seems to me that we have to look to the Federal Government to support these issues.

Dr. ANDERSON. The Academy of Family Physicians believes in the concept of managed care, because the concept implies that every person has a physician, a personal physician, and through that personal physician, they get the care that that doctor can provide or are then referred to the greater care providers, or I should say the greater health industry, for those services that one physician cannot provide. That is managed care. Managed care is better than unmanaged care. But as you say, we have now corporate stockholder organizations that are gaining great control of health care. I do not think we necessarily want stockholders deciding where and with whom we get our health care. That is legislation.

It is interesting that when you turn on the television, you will see dozens of advertisements on hospitals and care provider groups. To me, that is somewhat like advertising your fire department. We just spend billions of dollars doing the wrong things in health care.

Dr. ROSENFIELD. Just a couple of comments, and then I think Dr. Sullivan has a number of specific answers. One part of the public health agenda is to try to assess the changes that take place, to develop the quality assurance measures, the quality assessment, the outcomes measures, and such. And as we move into this new arena, we have got to demonstrate if it is good or if it is bad, and I think many of the concerns that you are expressing and that my colleagues have expressed are certainly there.

The original managed care approaches really were controlled by the staff, or the group of physicians that were involved, or by the patients.

Senator WELLSTONE. For example, if I could interrupt you, I think it may be a little symbolic—I grew up in this area, and my family was practically a charter member of Group Health, which has now been taken over by Humana. There is a difference between Group Health and Humana—a big difference.

Anyway, go ahead, please.

Dr. ROSENFIELD. On top of which—and I think this would be one of the things that needs to be assessed—some of these panels have a very high administrative cost, and in addition there is the profit cost. So that somewhere between 25 and 30 cents on the dollar goes to administrative and profit costs, and not to patient care. And this is not for this discussion now, but in the single-payer system in Canada, it is about 5 percent. So it is a big difference in those kinds of costs.

Senator WELLSTONE. Thank you.

Dr. Sullivan.

Ms. SULLIVAN. If I can remember your three questions, the first one had to do with the need for advanced practice nurses, if I recall.

Senator WELLSTONE. Yes, and in what locations.

Ms. SULLIVAN. I think there are two locations that we are aware of, and those are certainly the rural areas as well as the inner city underserved areas. I think there are dire needs for advanced practice nurses in those areas—not just nurse practitioners, but also

clinical nurse specialists who could do some of that home care that we heard about earlier.

Your second question was how effective has the NEA been on rural and underserved areas, and I can really only report the effects that we have had in Kansas. There are several. We had a continuing education grant to train nurses to assess and manage the frail elderly. That went for 5 years, and we went across the State and taught nurses to do that. For 15 years, we ran an outreach program that was initially funded through NEA that took our master's program across the State in seven sites, and we essentially populated the State with master's-prepared nurses.

But most recently and most successfully, a grant that we are conducting now is a collaborative program between our university, Wichita State University, and Fort Hays State University, which is in far western Kansas, to prepare nurse practitioners, and we are doing that using distance-learning technology. All classes are taught simultaneously. We have leveraged that money for some private foundation support in Kansas as well as some new State money, and this year, we will expand the program to Garden City, which is even more rural than Hays, and Pittsburgh.

Essentially, our goal—and we are doing it—is to prepare nurse practitioners across the entire, very sparsely populated State of Kansas. And the reason why it is successful is that we use nurses who are practicing in those communities now to come to those programs, and they do not have to go that far.

Senator WELLSTONE. I thank you very much.

Ms. SULLIVAN. And you had one more question—I am sorry. You asked what percentage do we get for nursing scholarships. We get 30 percent now, and we have 52 percent of the students. We believe we need at least $5 million a year in order to serve the disadvantaged students.

Senator WELLSTONE. I thank you.

Madam Chairman, perhaps I could submit a written question on this whole issue of Project 3000 by 2000. I am sort of interested in where the "3000" comes from, the basis of it, and whether it is really adequate.

Dr. COHEN. It represents parity from the population point of view.

Senator WELLSTONE. Thank you very much.

I thank each of you.

The CHAIRMAN. Thank you, Senator Wellstone.

Senator Jeffords.

Senator Jeffords [presiding]. First of all, I have spoken with Chairperson Kassebaum, and I am going to enter into the record an excerpt from a letter from Peter Taylor, executive director of the Vermont State Dental Society, which was not represented at this hearing. I will just read one excerpt and will enter the remainder in the record.

"Dentists are primary dental care providers. Individuals not only should, but usually do, have a primary care physician and a family dentist. Because of this unique separation, yet similarity in primary care function, dentistry's role must be recognized when Federal priorities are being established for primary care provider programs."

[Letter from Mr. Taylor follows:]

VERMONT STATE DENTAL SOCIETY,
132 Church St.,
Burlington, VT, March 6, 1995.

Honorable JAMES JEFFORDS,
513 Hart Building,
Washington, DC.

DEAR JIM: I know that Lyman Johnson and Jack Farnham have both contacted your office about an issue of great importance to the dental health of Vermont and U.S. residents. As you may have heard we wish to secure an opportunity for a dentist to testify at the March 8 hearing on Health Professions Programs. Dentistry is the only primary care profession that has been left off the witness list. In this regard we are requesting that you intercede with Senator Kassebaum.

Representatives of the American Dental Association and other dental organizations have also contacted your staff about this request.

Dentists are primary dental care providers. Individuals not only should, but usually do, have a primary care physician and a family dentist. Because of this unique separation, yet similarity of primary care function dentistry's role must be recognized when Federal priorities are being established for primary care programs.

Attached is a fact sheet that has been prepared on this topic. However, I would like to address some of these facts from Vermont's perspective.

1) Dental residency programs such as Jack Farnham's at Fletcher Allen ensures that general dentists have the expanded skills to retain the current 80 percent to 20 percent ratio of general dentists to specialists that we have in Vermont. Residency programs expand the skills of general dentists, thus reducing the need for a disproportionate share of dental specialists. (a model for the medical profession).

2) Our dental residency program is directly responsible for attracting 15 percent of the current dental manpower in Vermont. Many of these dentists are practicing in some of Vermont's smaller communities. Again we provide an example for the medical community from a geographic distribution perspective. (Please see the attached Vermont map showing the wide distribution of Vermont dentists throughout the state.)

3) The desire of government should be to support and stimulate a system which is not only working but is an excellent model for medicine to follow.

Jim, if the elimination of dentistry from these discussions continues because of our accomplishments in primary care efforts,it will be like saying, "Since the dental health of the population has improved it is now OK to remove fluoride from our drinking water. " We must continue to support the positive components of the existing system.

We would be most grateful if you would intercede on behalf of the continued dental health of Vermont's residents.

Sincerely,

PETER TAYLOR
Executive Director

American Association of Dental Schools

1625 Massachusetts Avenue, NW
Washington, DC 20036-2212

202.667 9438

GENERAL DENTISTRY PROGRAM FACTS

What is the taxpayer return on their investment in the General Dentistry program?

1. In FY 1994, $3.7 million was appropriated for the General Dentistry program. General Dentistry residency positions established through this federal program provide approximately $14 million in unreimbursed dental care each year.

2. Graduates of the General Dentistry program have broader skills and clinical experience and consequently refer fewer patients to specialists. This results in millions of dollars worth of reduced costs to patients each year.

3. Because they have treated a broad mix of patients, graduates of the General Dentistry residencies recognize early signs of diabetes, leukemia, oral cancer, HIV disease, etc., directing medically compromised patients to medical care and treating their oral health needs before the dental problems adversely affect the underlying condition. This early intervention helps control health care costs.

What about the GAO Report that questions the value of Health Professions (Title VII) and Nurse Training (Title VIII) Programs?

The GAO Report asserts that Title VII and VIII programs: 1) do not improve the supply of primary care providers 2) do not improve their distribution into underserved areas and 3) do not improve the minority representation of health professionals. The GAO Report criticizes the Department for failing to evaluate the effectiveness of these programs.

These criticisms do not apply to the General Dentistry program, which was subjected to a comprehensive evaluation in 1991, by statutory mandate.

The General Dentistry program improves the supply of primary care providers. Since the program's inception, 53 new programs have been established and 459 residency positions created nationwide, representing an increase of more than 62% in the number of these primary care positions. Eighty six percent of the graduates of these programs remain in primary care after graduation.

The General Dentistry program improves distribution into underserved areas. The off-site training component has resulted in at least 25 percent of recent graduates of federally supported General Dentistry programs establishing their practices in underserved areas.

The General Dentistry programs enroll a significant number of minority dentists and provide increased training for these individuals to provide primary oral health care services to underserved populations and communities. The enrollment of African American dental graduates into General Dentistry programs has nearly doubled since 1986. In fact, the percentage of enrollment in these programs is greater than the percent of African American dental graduates. Enrollment of Hispanic dental graduates into the program has paralleled the growth in the number of Hispanic graduates from dental school, increasing four-fold from 1986 to 1991.

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Senator JEFFORDS. That having been done, let me just ask a couple of questions. When I was in Detroit, looking at what they had done in reforming their health care system, the question of underserved areas came up, especially in the urban areas, and I was intrigued to find out that they have what I guess you would call an integrated system, but they were saying do not worry now, because we want to make sure our hospital beds are full, so we are locating primary care physicians in the urban areas to ensure that when somebody gets sick, they will come to us.

Is that happening, and is that answering the problem?

Dr. ANDERSON. That is the wrong approach to the idea, but that is what is happening. Hospitals are buying primary care practices, primarily family practices, right and left. And it would be interesting as we move on into managed care—those beds that they want full now, as soon as we get into managed care prepaid, capitated care, they are going to want them empty tomorrow.

Again, they are part of the corporate growth illness—I will not say "illness"—that we see going on right now. Again, we have been in a disease treatment mode, actually, for decades, and we need to start looking at disease prevention mode. And again, we will always have disease to treat, and we want to treat it the best we can, but again, those hospitals that want to be full tomorrow, as soon as they are paid with prepaid dollars, they will be pushing doctors to get patients out of the hospitals.

Senator JEFFORDS. Yes, Dr. Rosenfield?

Dr. ROSENFIELD. Just a brief comment. As we look at all the attention to managed care and some of the questions that have been discussed today, we need to continue to focus on the fact that prevention is of key importance, that the public health agenda is a key agenda, and the training of people to work in the public health arena to try to prevent disease and improve the health of the public is not something that is being considered by this moving train of managed care. It is something that I think this bill does deal with and is a very important component as we look at health care in the ensuing years.

Senator JEFFORDS. Thank you, Madam Chairman.

The CHAIRMAN. Thank you, Senator Jeffords.

Senator Abraham.

Senator ABRAHAM. Thank you, Madam Chairman.

I have just a couple of questions for Dr. Sullivan. You mentioned that the current allocation of dollars is approximately 30 percent of the scholarship dollars, to nursing students?

Ms. SULLIVAN. Yes.

Senator ABRAHAM. Versus 52 percent of the students.

Ms. SULLIVAN. Yes.

Senator ABRAHAM. Do you have any sense of what the cost differential is, though, as opposed to just the percentage of students, just to put that in context, because I would be interested in knowing what the education costs are for nursing students versus those in physician programs.

Ms. SULLIVAN. Well, I do not think I can give that to you off the top of my head, but I can get it for you.

Senator ABRAHAM. Fine.

Ms. SULLIVAN. Certainly nursing education is much less expensive than physician education, and most programs only have students in the last 2 years of their baccalaureate degree, so we are really only talking about 2 years of education. So it is considerably less—more along the lines of what a major public or private university would charge general students.

Senator ABRAHAM. I just wanted to make sure of the 30 percent figure—we were talking 52 percent versus 30, which seemed out of line, and then I thought maybe it is the dollars that are closer to 30 percent.

Ms. SULLIVAN. That is probably true, but we still think it is out of line.

Senator ABRAHAM. Well, I did not think you would think it was otherwise. [Laughter.]

I have another question. Within the nursing training programs—we have received a lot of letters, for instance, from constituents in our State from people who are teachers or are in the administration of nursing programs, for specific specialties. One area in particular is those who are training to become nurse anesthetists. And I guess my question is that that particular specialty, as far as I can tell from the correspondence, would seem to be much more demanding in terms of the time commitments, because of the nature of the programs, at least the ones in my State. Is that unique to that particular specialty, or are there a small number of specialty areas where the time demands are greater than others?

Where I am going is that they are arguing for specific set-asides of dollars within whatever nursing allocation there might be, because they say the people in those training programs are not in a position to basically maintain outside jobs or other types of income sources.

So I was wondering if you could comment on that, whether that is a unique problem to that particular specialty, if there are others like it, and whether you would favor that kind of distinction among the specialties?

Ms. SULLIVAN. No, I do not think that they are particularly unique. The nurse practitioner training program is equally as rigorous, in my opinion, as well as clinical nurse specialist training programs.

What has been different—and maybe this is what they are mentioning—is that because there has been such a small amount of Federal traineeship dollars, most of the people in graduate nursing programs have had to maintain employment and go to school part-time, necessitating 4 or 5 years for a year and a half program. But the nurse practitioner program at our particular school, we do not allow students to go part-time, so that having that support for their traineeships is equally important.

I think it is just a matter of how you structure the education, and I would not think that nurse anesthetist programs need any more than nurse practitioner programs.

Senator ABRAHAM. OK. I have a letter here from an individual who has been a program at one of our schools, Mercy College, and she argues that "nurse anesthesia programs are unique among graduate nursing education in their rigor," that their program con-

sists of "28 months of full-time study and requires over 80 hours per week of graduate course work and clinical internship."

Is that any different from the program at Kansas? Maybe it is just unique to the school.

Ms. SULLIVAN. Well, we do not require students to work 80 hours a week.

Senator ABRAHAM. OK. That is good. The students at Mercy may want to transfer. [Laughter.]

Ms. SULLIVAN. It might be a good idea.

Senator ABRAHAM. Maybe we will come up with a whole new labor issue here that we have developed, Madam Chairman.

Well, I was just trying to put it in perspective, because this is the one group that we have heard a lot from in the course of this discussion, and I just wanted to put it in perspective so I could respond to them as to what the sense was. Their argument, as I understand it, is that because people in this program are in a position to perhaps bring about some cost containment in the broader area of health care because of their ability to play the roles that they would and substitute perhaps for more expensive care or physician handling of matters, that they somehow should stay in a unique position. So I just wanted to get a sense of whether that—I can see a lot of heads saying no across this table, so I will let the others comment.

Ms. SULLIVAN. And I think the nurse-midwives and nurse practitioners—you will have all those organizations after you, too.

Senator ABRAHAM. I just wanted to build my defense.

Go ahead, Dr. Rosenfield, or any of the others, if you care to comment.

Dr. ROSENFIELD. You can hear appeals from almost every subspecialty area in nursing, medicine, and public health as being very special. We have needs across our fields, and the needs should not be divided by that kind of degree of specialization, in my opinion.

Dr. COHEN. Which is not to say the needs are not special.

Senator ABRAHAM. Well, just looking at the audience, I know what I am going to say next.

Madam Chair, thank you very much.

The CHAIRMAN. I think that is a good question, Senator Abraham, because it really shows that while the needs are special, everyone fears giving up his or her set-aside. And yet, because they are unique, I would argue they are going to be recognized as such and will be supported. But we must move away from trying to protect every little thing with a set-aside, and it is always hard to make those decisions. But that is a good question, because we have all received and will be receiving some of the same kind of mail.

Senator ABRAHAM. I appreciate it.

The CHAIRMAN. I thank everybody for coming this morning. They have been exceptionally good panels, and I am very appreciative of the support that we have been offered and have been given to help us put together this legislation.

Senator Mikulski has asked that a statement be included in the record and additional statements and material submitted for the record.

[The prepared statement of Senator Mikulski and additional statements and material submitted for the record follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Good morning. I'd like to thank Senator Kassebaum for arranging this hearing today. You and your staff have put together an impressive array of materials and panelists to help us as we review Titles VII and VIII of the Public Health Service Act and prepare for their reauthorization.

The goals of these provisions are noble: (1) to increase the supply of primary health care providers; (2) to improve their representation in rural and medically underserved areas; (3) to improve minority representation in the health professions. We must ensure that these goals are being and will continue to be met. These programs must be responsive to the changing demographic profile of our country both in terms of geographic distribution and minority populations.

The changes you are proposing in these Titles will not only affect the way that health professionals schools train their students but will determine who goes into the health professions and whether we have a sufficient number of health professionals to serve the needs of the diverse populations in our nation. I know that some of the health professions groups have some concerns about the consolidations you are considering and I am interested in their reactions to the proposal.

Although I believe that we must look to ways to improve the law and meet the goals we have set out for these programs, including consolidation, I also believe we must be certain that we are not hurting programs that have worked well.

One program that has worked extremely well is the Alzheimer's Demonstration Grant Program. This program shows how Federal funds can be channeled to States to stimulate creative thinking. The goal of the program is to tie Alzheimer's families to existing service systems and to help fill the gaps in those systems. With less than $5 million a year from the Federal Government, 15 States, including my own State of Maryland, have developed innovative strategies to help Alzheimer's families, focusing particularly on hard to reach underserved minority and rural communities.

The impact of this minimal Federal investment has been enormous. The program has reached an estimated 4.5 million persons. Grant recipients have provided educational seminars and workshops to nearly 400,000 care givers, community service providers and volunteers, and over 2,100 families with a member with Alzheimer's are receiving respite services including adult day care, in home and overnight care.

The States involved in these programs are taking what they are learning and sharing it with state officials and community organizations across the country. This may be the most important part of the program. As States try to plan and adjust to the massive changes this Congress may impose, they are going to need the demonstrated expertise of these programs to respond to the needs of the 4 million Americans who are living with Alzheimer's disease today.

Last year, this committee and the Senate approved this legislation as part of a larger minority health professions bill. The House was prepared to accept the Senate amendment but, like so many

things at the end of the session, action was never completed. I am grateful to the Chair for putting this issue back before the committee has part of this year's Health Professions bill.

Thank you again Madam Chairwoman.

JOINT PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PREVENTIVE MEDICINE AND THE ASSOCIATION OF TEACHERS OF PREVENTIVE MEDICINE

The American College of Preventive Medicine (ACPM) and the Association of Teachers of Preventive Medicine (ATPM) are pleased to submit jointly this statement concerning the reauthorization of health professions education programs under Title VII of the Public Health Service Act. ACPM is the national medical specialty society of physicians whose primary interest and expertise are in preventive medicine. ATPM is the professional organization of academic departments, faculty and others concerned with undergraduate and postgraduate medical education in preventive medicine.

ACPM and ATPM support a redefinition of the goals of Title VII programs and concur with the need to define measurable objectives. We are very grateful to Senator Kassebaum and the Committee for asserting thoughtful leadership in undertaking this task. We support the broad outlines of Senator Kassebaum's proposal as we now understand it, and appreciate particularly the Senator's recognition of distinctive training and workforce requirements in preventive medicine. The purpose of this statement is to describe the roles of preventive medicine both in our nation's public health system and in primary care systems, and to suggest ways in which the proposal could be revised to account for both these roles.

WHAT IS PREVENTIVE MEDICINE?

Prevention, in its broadest sense, is practiced by all physicians and other health professionals who help their patients stay healthy. It also is the principal goal of our nation's state and local health departments, who perform core functions in health protection and promotion that no single private institution or health provider can fulfill. The specialty of preventive medicine bridges the gap between the perspectives of clinical medicine and public health. Specialty training in preventive medicine requires one year of clinical training, one year of academic training to receive a master's degree in public health or the equivalent, and one year of supervised practicum experience.[1]

The core of preventive medicine is that it brings. the medical/scientific model of practice, applied by clinicians to diagnose and treat individual patients, to populations, or groups of individuals. Just as the primary care clinician provides integrated preventive, diagnostic and therapeutic services to individuals, the preventive medicine physician continuously monitors the health of a defined population, evaluates the risks to the health of that population, and intervenes to address those risks.

The tools of preventive medicine are the population-based health sciences, including epidemiology, biostatistics, environmental and occupational health, planning, management and evaluation of health services, and the social and behavioral aspects of health and disease. These are the classic tools of practice in public health agencies, but they have grown in importance in other health care settings where there is increasing recognition that improving the health of a patient population and reducing the costs of medical care also require application of the population-based health sciences.

Departments of preventive medicine, community medicine, or social medicine in medical schools, schools of public health, and preventive medicine residency programs (which are located in medical schools, schools of public health, and a few health departments), are the loci of expertise in the population-based health sciences. These disciplines, however, are not and should not be the exclusive province of public health or preventive medicine specialists. They should also be an integral aspect of the training and practice of all health professionals who provide primary care or who contribute to primary care systems. Increasingly they are indivisible from clinical decision-making, as well as from such areas as outcomes research,

[1]The American Board of Preventive Medicine certifies physicians in three specialty areas: general preventive medicine/public health; occupational medicine; and aerospace medicine. This statement refers only to the specialty area of general preventive medicine/public health, the field of preventive medicine whose residency programs have been funded under Title VII of the Public Health Service Act.

quality improvement, and the management and information sciences with which all primary care practitioners now need to be conversant.

We believe, therefore, that federal support for preventive medicine training not only can help meet the workforce needs of medically underserved geographic areas and public health departments, but also can have a synergistic effect by strengthening the ability of health professions schools to respond to a rapidly-evolving health care system by teaching the population-based health sciences as an integral aspect of primary care.

THE IMPACT OF FEDERAL SUPPORT FOR PREVENTIVE MEDICINE TRAINING

The small sums appropriated for preventive medicine residency training under Title VII have been the exclusive federal support for programs training physicians in general preventive medicine and public health (other than the residency programs conducted by the Centers for Disease Control and Prevention and the military). Medicare graduate medical education funds have been largely unavailable to these programs because they are based not in hospitals but in community outpatient and public health settings. Because preventive medicine programs derive little or no revenue from one-on-one patient care, this common source of funds for physician training also is unavailable.

Currently, residency programs scramble to patch together funding packages for their residents. Funding from any source is available for only 60 percent of preventive medicine residency positions. The remainder of the openings go unfilled due to lack of funds, and potential applicants must be turned away.

A 1991 survey of all 1,070 graduates of general preventive medicine/public health residency programs from 1979 to 1989 conducted by Battelle, an independent consultant under contract to the Centers for Disease Control and Prevention and the Health Resources and Services Administration provided a clear picture of the accomplishments of the training programs and the impact of these federal funds. A majority of the graduates have initiated or managed major programs in prevention and control of infectious disease, chronic disease, sexually transmitted diseases, or maternal and child health. In addition to creating and running community health programs such as these, 60 percent of the graduates engage in research in disease prevention and health promotion, and 70 percent also take care of individual patients.

This survey also documented that funds invested in training these physicians have a lasting impact. Ninety percent of preventive medicine graduates remain involved in public health or preventive medicine. Moreover, Title VII funds were shown to be directly related to the viability of preventive medicine residency programs. In programs that have received federal grants, the number of graduates has more than doubled since 1983. Conversely, the number of graduates of programs that no longer receive federal funds has decreased significantly.

The Council on Graduate Medical Education (COGME) has consistently found a shortage of physicians trained in preventive medicine and recommended increasing the supply of such physicians as a national goal. Federal policies concerning the financing of graduate medical education, however, have yet to respond to this recommendation.

PREVENTIVE MEDICINE IN PUBLIC HEALTH DEPARTMENTS

Preventive medicine residencies have a long tradition of training and placing physicians in public health departments. The Battelle survey showed that about 21 percent of general preventive medicine/public health graduates were employed in state and local health departments. Moreover, five state health departments and two local health departments run their accredited residency programs for the purpose of training public health physicians.

The preliminary proposal for restructuring Title VII recognizes this role clearly by providing for support of preventive medicine residencies independent of primary care residencies in clinical specialties and establishing a funding preference for those residencies that place graduates in public health departments. We fully support this aspect of the proposal, and recommend that the legislation clarify that public health departments with accredited residency programs are themselves eligible to apply for funds.

The preliminary proposal also addresses public health workforce shortages by consolidating various scholarship and loan programs into a flexible National Health Corps program in which public health professionals would qualify to participate by serving in state and local health departments. We also support this approach, and urge that non-physicians trained in accredited medical school graduate programs in public health be included among the eligible professionals.

PREVENTIVE MEDICINE IN PRIMARY CARE SETTINGS

Preventive medicine specialists in their roles as physicians to defined population do serve communities of patients in such settings as community health centers and health maintenance organizations. Some residency training programs place heavy emphasis on training in community-oriented primary care, in which clinical primary care and population-based health services are integrated, and their graduates continue to work in these settings. Moreover, an increasing number of preventive medicine residents, about half the entering residents, have also been trained in a clinical primary care specialty. They are, therefore fully qualified to play dual roles in providing both comprehensive primary patient care and community health services.

We strongly urge, therefore, that a funding preference for preventive medicine residencies whose graduates go on to serve in underserved areas be added to the preference for those whose graduates serve in public health departments. Such a preference would recognize the important role of preventive medicine in enhancing primary care services and help encourage community-oriented primary care in underserved areas.

For the same reason, we also strongly recommend that legislation clarify that preventive medicine physicians are eligible to participate in the new National Health Service Corps program. The advisory committee to the current program has recommended that preventive medicine physicians be added to the list of eligible providers. The growing recognition of the importance of population-based health services in primary care settings and the objective of adding to the flexibility of the program amply justify such a provision.

ACPM and ATPM look forward to the committee's deliberations on health professions education and are eager to work with the committee to find the most efficient ways to apply limited resources to help meet national workforce objectives.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR RESPIRATORY CARE

The American Association for Respiratory Care (AARC), a 37,000 member professional association, welcomes the opportunity to submit written testimony on the hearing regarding the consolidation and reauthorization of the Health Professions Education Program The purpose of our testimony is to encourage the committee to support provisions for allied health education and training initiatives.

Respiratory care is an allied health specialty performed under medical direction for the assessment, treatment, management, diagnostic evaluation, and care of patients with diseases of the cardiopulmonary system. Respiratory care practitioners care for patients ranging from the premature infant whose lungs are underdeveloped to the elderly patient whose lungs are diseased. Individuals who suffer from diseases such as emphysema, bronchitis and lung cancer; children who suffer from asthma or are afflicted with cystic fibrosis; and patients of all ages who require the use of a ventilator to breathe—they are all often cared for by the respiratory care practitioner.

The Association supports the need to curtail federal spending and consolidate fund initiatives into more workable and more efficient programs. We are concerned, however, that the important programs supporting the allied health professions' grants under Section 767 of the Public Health Service Act will be effectively terminated. We would hope Congress will specify, either within the reauthorization legislative language or via report language, that at a minimum, allied health programs or personnel would be eligible to participate in the newly created block grant educational programs. As the association representing respiratory care practitioners, we would urge that respiratory therapy specifically, or allied health professions in general, be delineated as participating professions in the National Health Service Cows Scholarship and Loan Repayment Program.

Two million allied health professionals representing approximately 50 percent of this nation's entire health workforce have a major role in providing a comprehensive range of primary care, diagnostic treatment, and rehabilitative services in a wide variety of settings. Currently, there are over 100,000 respiratory care practitioners throughout the country. 7he ability of the allied health professions to contribute to primary care is impeded, however, due to severe workforce shortages which characterize several of these occupational groups, especially in rural and inner-city areas.

Increased amounts of home health care will have to be provided to older patients; allied health professionals such as respiratory therapists will figure prominently in providing the necessary services and an inadequate supply of allied health practitioners will make it increasingly more difficult for these less costly alternatives to be used to maximum advantage.

Innovative programs initiated under the Allied Health Special Projects Grants such as developing multiskilled allied health practitioners will better meet the health care needs of this nation's citizens as we move toward the 21st century. These forward-looking programs have been created under the project grant, and the results are being disseminated across the country by changing the professions' educational course curriculum. We fear that these types of projects for allied health will be subsumed during the restructuring efforts.

We would point out that even a written document developed by Labor and Human Resources Committee staff have noted the success allied health has had in providing health care practitioners in underserved areas. We would also point out that the same document further states that funding is so small for allied health that there may be little overall nationwide impact. We would urge the committee not to erase the impact allied health funding is having, small as it may be. We would recommend that reauthorization legislative language specifically permit allied health to effectively compete in the various health professions education consolidated programs.

Prepared Statement of the National Association of Insurance Commissioners

INTRODUCTION

Good morning Mr. Chairman and members of the subcommittee, my name is Brian Atchinson. I am Vice President of the National Association of Insurance Commissioners (NAIC) and Superintendent of the Bureau of Insurance for the State of Maine.

The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I would like to thank you for providing me with the opportunity to address you this morning concerning the experiences of consumers and the state insurance departments with the federal Employee Retirement and Income Security Act, also know as "ERISA".

As you know, ERISA is a complex statute with broad applicability to the regulation of employee benefit plans in both the pension and health plan area. Indeed, ERISA has established many needed protections for beneficiaries of employee benefit plans—particularly pension plans. However, ERISA provides inadequate protections to employees who receive their health benefits through health plans governed by ERISA. Today, I will address what state regulators believe to be the shortcomings in ERISA's regulation of employee health benefit plans.

The state insurance regulators believe that health care consumers who receive their health benefits through health plans governed by ERISA deserve heightened protection in several areas. First, all consumers of health care coverage should have the benefits of enhanced portability and a reduction in the use of exclusions and rate hikes based upon an individual's or group's health status. Thus, insurance reforms should be made applicable to all types of health plans, whether they are governed at the state or federal level. Second, employees should be provided with a low cost, accessible and meaningful way to address complaints they may have with either the administration or benefits provided through their health plan. Third, employees have a right to have the terms of their health plan disclosed to them in a clear and understandable fashion and to be assured that the plan will abide by these terms. Fourth, all ERISA health plans should be subject to requirements which assure that they are solvent—that is, that they are able to provide the benefits they have promised beneficiaries. Finally, all health plans should be required to conform to quality control measures and report uniform data relating to the services provided to their beneficiaries. Such requirements will assure that consumers are provided with quality health care. In addition, in these days of spiralling health cue costs, data collection concerning these plans will enable policymakers to understand where health care dollars are being spent so that they can work to control overall health care costs.

BACKGROUND: ERISA AND THE GOVERNANCE OF EMPLOYER HEALTH PLANS

Admirably, the overarching and express purpose of ERISA is the protection of beneficiaries of employer-sponsored benefit plans. The preamble to the statute states that the statute seeks to protect:

the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, re-

sponsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the federal courts.

29 U.S.C. Sec 1001(b). (emphasis added). Importantly, employer health plans governed by ERISA are not excluded from this purpose. Thus, the statute seeks to protect the interests of beneficiaries of all employee benefit plans governed by ERISA—including health plan beneficiaries.

However, many important consumer protections were omitted from the portion of ERISA governing health plans. In fact, the provisions in ERISA relating to health benefit plans only make up a small portion of the statute itself. Twenty years after the enactment of this statute, consumers continue to experience the detrimental effects of this imbalance.

ERISA currently contains sweeping language which preempts many state laws which would otherwise govern employer-sponsored health plans. ERISA preempts state laws "insofar as they may now or hereafter relate to any employee benefit plan . . . ." 29 U.S.C. Sec. 1144(a). The statute exempts state laws regulating insurance from this preemption. However, twenty years and many court decisions later, the one thing that is clear from this statute is that this preemption language is both far-reaching and confusing. Thus, in addition to the gaps in consumer protections under ERISA, there has been great uncertainty regarding its interpretation. The scope of ERISA's preemption and the lack of clarity in the statute has had a "chilling effect" on certain state-level health reform activity.

For the purpose of this testimony, I will call all health plans governed by ERISA "ERISA health plans". However, it is important to note that the nature of the federal requirements, and the extent to which the plan is subject to certain state laws, depends upon the specific structure of the plan. For example, different requirements apply to single employer-sponsored plans, as opposed to those formed pursuant to collective bargaining agreements. Furthermore, if an employer chooses to provide his or her employees with "insured coverage"—the substance of that coverage and the solvency of the plan is regulated by the states. Whereas if an employer "self-funds" the coverage, the regulation of the plan, to the extent to which such regulation takes place, is entirely at the federal level. In either event, however, a broad array of elements of such plans are regulated by ERISA.

ERISA has had a huge impact upon the delivery of health care coverage in this country. A recent study by the General Accounting Office in 1993 estimated that only 24 percent of Americans received their health coverage through insured plans governed by the states. Health Insurance Regulation: Wide Variation in States' Authority, Oversight and Resources, GAO/HRD-94-26, December 27, 1993. That means that the remaining portion of the American public that has health care coverage receives this coverage through plans governed by ERISA—or through Medicare and Medicaid and other public programs. The growing portion of the population which is receiving its coverage through ERISA-governed arrangements makes it all the more important that Congress ensure that beneficiaries of ERISA health plans are accorded meaningful protections with regard to this coverage.

INSURANCE REFORM AND ERISA HEALTH PLANS

Several Members of the 104th Congress have introduced bills which include market-based, incremental reforms of the health care system. I understand that Chairman Fawell soon will introduce such a bill. Many bills include reforms of the insurance market in order to achieve enhanced portability and affordability of consumers health care coverage. Such reforms build upon the strengths of the existing market and include restrictions on the ability of plans to exclude or delay coverage due to persons' preexisting health care conditions and require that plans issue coverage to employer groups regardless of their health status.

As many of you know, the states have paved the way in the area of small group insurance reform—and are continuing to do so. To date, forty-seven states have enacted some type of small employer group insurance. In fact, all but one state represented on this subcommittee has enacted small group health insurance reform legislation. Many of these state laws are based upon the NAIC's Small Employer Health Insurance Availability Model Act, adopted by the NAIC in 1991. The NAIC Model Act, and the reforms enacted in most states, are designed to enhance market competition by creating a level playing field within the insured marketplace regulated by the states. These reforms limit the ability of insurers to raise rates due to the claims status or experience of a certain group. They also enhance portability by prohibiting insurers from imposing preexisting condition limitation on groups which had previously qualifying coverage.

However, the states need your help in expanding the scope of these reforms. ERISA constrains the states' ability to promote portability among all types of em-

ployer-sponsored plans. The states are unable to apply their insurance reform statutes to ERISA health plans. The NAIC urges that Congress, if and when it enacts health insurance reform legislation, do so in a manner that ensures that the same reforms apply to insured and non-insured plans. Such a level playing field requires uniformity of not only the standards imposed, but of the stringency and level of oversight of these plans.

If proposed federal health insurance reform legislation creates a construct under which certain ERISA health plans and insured plans are subject to the same standards, but the enforcement of these standards is bifurcated between the states and the federal government—it is imperative that the level of oversight and accountability of these plans at the federal level be significantly increased from that which currently exists under ERISA.

It is also critical that any federal health insurance reform legislation address the individual health insurance market. For self-employed individuals, as well as other individuals who do not receive coverage through an employer or otherwise, this market often offers them their only chance at coverage. Unfortunately, in most states, small group insurance reform laws do not extend to the self-employed population. Furthermore, although some states have acted in this area, many states have not extended reforms, such as limits on insurers' ability to increase rates based upon a person's medical condition, or limits on the use of preexisting condition restrictions, to the individual health insurance market. Consequently, just when people need it most—in times of transition, when starting a business on their own, or when working for an employer who does not offer coverage, many individuals find themselves denied coverage due to their past medical history, or are faced with unaffordable, spiralling premium costs.

The NAIC has been working on amendments to its small group reform model act which would extend the protections of small group reforms to one life self-employed groups. It is likely that these amendments will be adopted by the NAIC's full membership at its National Meeting next month. In addition, the NAIC has made it a priority to develop a model law to address some of the inequities in the individual market over the coming year.

Such state level reforms are indeed important and can enhance the availability and affordability of insured health care coverage. However, these reforms do not take place in a vacuum. To the contrary, the potential success of such state-level reforms is directly linked to the breadth and varied health status within the insured marketplace. If the market incentives are such that only healthy groups will find it beneficial to self-fund their coverage, the insured market place will become the refuge of individuals and employer groups with poor or "high risk" health status. Such an occurrence would make it virtually impossible to stabilize rates within the insured marketplace in a way which would make coverage truly affordable. It is therefore imperative that any federal insurance reforms create a truly level playing field—both in terms of the standards imposed, the level of oversight and the coverage demands placed upon each segment of the marketplace.

The partnership created between the federal government and the states in the development and enforcement of standards for Medicare Supplement insurance is an example of a way in which the federal government has promoted uniform standards across the country but has availed itself of the ongoing strength of the state insurance departments: consumer protection. In that instance, the states, through the NAIC, worked to develop the standards and currently implement and enforce these standards. The NAIC stands ready to offer the technical expertise of the states to members of Congress, and their staff, as you consider insurance reforms. We encourage you to build upon the proven success of this type of federal/state cooperation.

CONSUMER COMPLAINTS AND ERISA

Currently, ERISA does not assure that beneficiaries of ERISA health plans have access to meaningful internal nor external complaint procedures nor remedies.

INTERNAL APPEALS AND REVIEW OF HEALTH PLAN DECISIONS

ERISA does not guarantee that participants in both insured and self-funded ERISA health plans have an unbiased and independent internal review process. The statute does require that health plans provide a mechanism for participants to appeal a plan's denial of a participant's claim. However, if a person is dissatisfied with the result of this appeal, the next level of review may be conducted by the same fiduciary party who denied the claim initially. Thus, plan participants do not have the opportunity to seek an independent internal review of a plan benefit decision.

REVIEW OF CONSUMER COMPLAINTS BY A PUBLIC AGENCY

What can a beneficiary of an ERISA health plan do if he or she is dissatisfied with a decision made by his or her health plan? Unfortunately, ERISA plan participants do not have recourse to a public agency that has jurisdiction over these plans and the capacity to respond to the beneficiary's concerns in a timely and aggressive manner. The beneficiary may file a complaint with the U.S. Department of Labor. However, the Department of Labor's employee benefit complaint review program is very limited—as the Department itself has admitted.

The Department of Labor's Task Force on Assistance to the Public (1992) stated that, for complaints that appear to have merit, its Division of Technical Assistance and Inquiries tries to seek a response from plan administrators. However, if the plan official does not agree to approve the benefits, the staff member will not pursue the matter further. Instead, DOL staff will either suggest that the claimant seek legal counsel or will refer the matter to the DOL's Office of Enforcement. Thus, as the Department of Labor's Task Force noted, the Department of Labor does not have an explicit statutory mandate to assist individuals who wish to pursue complaints related to ERISA health benefit plans and its activity in this area is minimal.

By contrast, while participants in self-funded ERISA health plans only can appeal to an ill-equipped Department of Labor, beneficiaries of insured ERISA health plans have access to state insurance departments to obtain an independent and informal review of their complaints. Many state insurance departments try to help beneficiaries of ERISA self-funded and insured health plans, although they have no jurisdiction over the self-funded plans and limited jurisdiction over the insured ERISA health plans. For example, during 1994, the Wisconsin Insurance Department received 996 complaints relating to self-funded ERISA health plans out of a total of 4,666 complaints concerning health care coverage. Thus, complaints regarding self-funded ERISA health plans comprised over 20 percent of the complaints regarding health care coverage received by the state's insurance department last year, even though it has no enforcement authority over these plans. Despite its lack of jurisdiction over these entities, the Wisconsin Insurance Department was able to help beneficiaries recover $281,347 from these plans. One could only speculate as to the additional numbers of beneficiaries of such plans who had complaints, but did not even attempt to call the state insurance departments—perhaps because they realized that the department did not have jurisdiction over these plans. The Alaska Insurance Department recently reported receiving approximately twenty-five calls a week from consumers having problems with self-funded ERISA health plans.

Clearly, ERISA fails to provide participants with an effective external administrative appeal mechanism.

LIMITED REDRESS AVAILABLE TO ERISA PLAN BENEFICIARIES THROUGH LITIGATION

As noted above, if participants in ERISA health plans feel they have been aggrieved by the decisions of their plan administrators, they may not have much success with the limited internal and administrative remedies available under ERISA. Consequently, despite the difficulty and expense presented by this option, a beneficiary may choose to pursue his or her claim through litigation. Importantly, it is unlikely that someone will choose to litigate smaller claims. Therefore, for many claims, ERISA provides consumers with no meaningful remedy. Furthermore, even when a beneficiary pursues a court suit, ERISA seriously restricts the avenues of redress available to ERISA beneficiaries.

ERISA does permit a participant to bring a court action for recovery of benefits which an ERISA health plan owes them. However, the plan can remove most state court actions to federal court—a forum in which plaintiffs often must wait for many years before their claim can come to trial. In addition, once in federal court, ERISA preempts many state law claims. For example, it preempts a state common law cause of action for failure to process a benefits claim in good faith.

Furthermore, ERISA prevents states from implementing innovative dispute resolution mechanisms for participants in ERISA health plans. Hence the states' hands are completely tied; ERISA hampers state efforts to spare individuals and businesses the cost and time of litigation.

Thus, as outlined above, ERISA seriously impairs the ability of ERISA participants to enforce the benefits provided to them by ERISA health plans. Congress should correct this egregious deficiency within the statute. The current scope of ERISA's preemption of state law remedies only should remain if statutory changes are enacted which assure meaningful governmental oversight and authority over ERISA health plans' claim and coverage determinations. Further, participants must be provided with internal and external appeal mechanisms in addition to the right to appeal to federal court.

FAIR DISCLOSURE OF TERMS OF COVERAGE

ERISA fails to ensure that ERISA plan beneficiaries receive complete and meaningful disclosure of plan benefits and plan changes. While the statute does require health plans to distribute a summary of the plan, annual reports and a summary of material modifications to the plan to plan participants, it does not require any outside or administrative agency review of the documents. Furthermore, if a plan has been changed, ERISA does not require prompt notification of the changes. Instead, plan administrators have as long as 210 days—over six months—to notify beneficiaries of plan changes.

This absence of meaningful notice under federal law contrasts with the rights available to beneficiaries under state law. If an employee is fortunate enough to have an employer who is offering an insured plan, the plan's policy forms are subject to review by the state insurance departments. Most states also require insured health plans, including insured ERISA health plans, to give participants prompt notice of changes to the plans. Beneficiaries of non-insured ERISA health plans are at the mercy of their plan.

FAIR COVERAGE

Critics of state insurance laws often object to the benefit requirements under certain state laws as overly onerous and restrictive. However, let us examine the shocking effect of ERISA's absence of coverage requirements. A family, the Browns, had a child born with severe congenital defects. Their self-funded single employer-sponsored ERISA plan refused to provide coverage for the child because it only covered newborns thirty-one days after birth, and, even then, only provided coverage if these newborns had no disabilities. For years, state insurance law has banned such shocking and disgraceful exclusions. However, when the Brown family challenged this exclusion in court, the U.S. Court of Appeals for the Fifth Circuit was forced to acknowledge that ERISA's preemption of state insurance laws left the Browns without coverage for their child. See Brown v. Granatelii, 897 F.2d 1351 (5th Cir. 1990).

While we would agree that employers should have certain flexibility with respect to the coverage they offer employees—consumers deserve more protection than that currently provided by ERISA.

ERISA should be revised to ban egregious exclusionary practices.

In addition, ERISA has permitted ERISA health plans to terminate or reduce the maximum amount of benefits provided for a certain type of illness. This has had particularly onerous consequences for individuals with disabilities or life-threatening illnesses, such as AIDS. See McCann v. H & H Music, 742 F. Supp. 392 (S.D. Tex. a 1990) affd 946 F.2d 401 (5th Cir. 1991), cert. denied 113 S. Ct. 482 (1992). The a American with Disabilities Act ("ADA ") of 1990 has improved the situation somewhat.

The U.S. Equal Employment Opportunity Commission (EEOC) has issued enforcement guidelines under the ADA which only allow an ERISA health plan to terminate benefits if the plan can demonstrate that the benefit termination is not a "subterfuge" or made with the subjective intent to discriminate against a particular disability. See "Interim Enforcement Guidance on the Application of the ADA to Disability-Based Distinctions in Employer Provided Health Insurance", EEOC, June 8, 1993. However, the federal courts have not definitively interpreted the relationship between ERISA health plan discretion and individuals' rights under the ADA. The application of the ADA to ERISA health plans should be clarified by federal statute. Further, since the ADA does not apply to very small employers, federal law should clearly prohibit all ERISA health plans from discriminating against particular groups or disabilities in their provision of health care coverage.

ERISA HEALTH PLANS SHOULD BE SUBJECT TO SOLVENCY REQUIREMENTS

Unlike pension plans, ERISA health plans are exempt from any meaningful financial standards or oversight. Self-funded ERISA health plans are specifically excepted from ERISA's minimum participation standards, minimum vesting standards, benefit accrual requirements and minimum funding standards. Therefore, ERISA does not subject self-funded health benefit plans to the same initial financing standards as it does pension plans. ERISA also contains no requirements to regulate the continued solvency of self-funded ERISA health plans once they go into operation. Even worse, ERISA provides absolutely no financial safety net for the beneficiaries of self-funded ERISA health plans. This omission stands in sharp contrast to state guaranty funds, which undergird insured plans—including insured ERISA health plans, and the Pension Benefits Guarantee corporation, the safety net for pension plans.

EAISA's limited requirements relating to the payment of claims have no teeth. While ERISA obligates claim fiduciaries to pay valid claims submitted—this does little to help plan participants if a plan goes insolvent. In such a case, participants can do little other than join the bankrupt employer's other creditors to pursue the firm's remaining assets.

ERISA should recognize that all entities which bear risk in connection with the provision of health care coverage, including ERISA health plans, should be subject to financial regulation and standards. These include initial capital requirements, risk-based capital requirements (capital requirements adjusted for the level of risk assumed by the entity) and effective protection for participants in the event of health plan insolvency. Furthermore, all types of health plans should be subject to ongoing regulation of their financial condition.

QUALITY HEALTH CARE

With the increased prevalence of managed care in the health care market, the administration of ERISA health plans have become inextricably linked with the quality of the health care provided through the plan. For example, plan hospital preauthorization requirements or utilization review requirements can determine whether a beneficiary has access to coverage for certain medical care. Many states regulate heath plan utilization review procedures. However, in the case of ERISA health plans, federal courts have held that such procedures relate to the administration of a health care plan and therefore are preempted by ERISA. ERISA's preemption therefore removes an important existing check on the quality of ERISA health plans—and provides no meaningful federal replacement for this void.

Federal courts have expressed concern regarding the scope of ERISA's preemption in this area. In addressing the question of whether ERISA shielded a self-funded ERISA health plan from claims relating to actions performed in connection with the administration of the plan, the court for the Third Circuit noted that "[ERISA] removes an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system . . . there is no deterrence for substandard medical decision making . . . bad medical judgments will end up being cost free . . . ERISA health plans will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices." Corcoran v. United Health Inc., 965 F.2d 1321, 1338 (3d Cir. 1992). The NAIC shares the Court's concern.

ERISA should be amended to provide plan participants with a way to seek redress if they suffer an injury due to the negligence or malfeasance in the administration of a plan.

DATA REPORTING

When used appropriately, health data on plan participants can lead to better management of health care costs, employee prevention and education efforts, improved quality of service and more effective coverage. However, at the moment there are no federal requirements which subject non-insured ERISA health plans to quality standards or any data reporting requirements. Further, states are restricted from requesting such information from these plans—thus thwarting any efforts to monitor and improve the overall health status of communities. Furthermore, ERISA currently does not address the privacy concerns of participants in ERISA health plans.

ERISA should be revised to allow for the collection of health data concerning ERISA health plan participants and to protect the privacy and confidentiality of sensitive beneficiary information.

CONCLUSION

Since its enactment, ERISA's provisions relating to employee health plans have had increasing import and meaning for the millions of Americans who receive their health care coverage under these arrangements. As I have spelled out, we urge you not to forget these Americans when you consider enacting federal health insurance reform. Any federal insurance reforms should be made applicable to ERISA health plans. Furthermore, every American deserves to be able to understand and enforce the terms of their health care coverage offered by their employer. This requires affordable avenues of redress and meaningful access to independent parties to help them pursue their claims. Furthermore, there is a place for government in health care coverage. Effective regulatory oversight can ensure plan solvency and provide quality controls to avoid abusive denials of medical coverage when individuals most need it.

The NAIC looks forward to working with the 104th Congress as it attempts to enact meaningful market-based reforms of the health care coverage market.

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE,
6110 Executive Boulevard,
Suite 405, Rockville, MD, March 13, 1995.

The Honorable Nancy Kassebaum, Chair,
Committee on Labor and Human Resources,
United States Senate,
Washington, DC.

DEAR MADAM CHAIRMAN: I am Olen E. Jones, Jr., Ph.D. and I am President of the West Virginia School of Osteopathic Medicine. I also serve as Chairman of the Board of Governors of the American Association of Colleges of Osteopathic Medicine, or "AACOM", which represents all sixteen colleges of osteopathic medicine.

Madam Chairman, on behalf of AACOM, I would like to express my sincere thanks to you and the Committee for affording us the opportunity to present our views regarding reauthorization of health professions education programs under Title VII of the Public Health Service Act. We certainly appreciate the past efforts of this Committee to maintain a commitment to health professions educational assistance and the openness that you and your staff have encouraged in the discussions about the programs since you assumed the chair of this Committee.

We also recognize the responsibility of the Committee to examine all programs in light of their effectiveness in meeting the health care needs of all Americans in a fiscally responsible fashion. We believe that colleges of osteopathic medicine measure particularly well under such examination.

Primary care is and has always been part of the osteopathic medical education fabric for over 100 years. Nearly thirty percent of the lull-time faculty in all sixteen schools teach family medicine, pediatrics and internal medicine. This emphasis is even more evident among the adjunct faculty of our schools. Half of these faculty teach in primary care departments.

Similarly, AACOM member schools have a long history of dedication to training primary care physicians to work in America's smaller communities. Indeed, the very first sentence of the mission statement of my own school, the West Virginia School of Osteopathic Medicine, states that we are "committed to providing family physicians for rural West Virginia and Appalachia." Consistent with the mission statement, we emphasize family medicine and primary care in our recruitment and admissions strategies. This philosophy continues throughout the osteopathic medical students' education. The average student at the West Virginia School of Osteopathic Medicine will spend thirteen of his or her final 24 months studying primary care on-site in community-based, often rural settings, such as solo practitioner's offices, community clinics, and regional hospitals. Our record of service in West Virginia is typical of all sixteen Colleges of Osteopathic Medicine. Nearly two-thirds of all osteopathic medical school graduates practice in primary care settings.

Madam Chairman, we think we have performed well, but much remains to be done. The health professions education programs of Title VII of the Public Health Service Act have been essential in facilitating our colleges' ability to train students to meet the health care objectives identified by the Congress. Let me identity those programs currently within Title VII that have been especially important to our schools.

The Family Medicine curriculum grants have been essential in the planning, development, and operation of training programs in family medicine, a centerpiece of primary care. The shortage of family physicians and other generalists physicians has been well documented by the Council on Graduate Medical Education (COGME). According to COGME, family physicians are more likely to practice in rural areas, are more cost-effective than other specialists, and treat approximately 85 percent of patient complaints.

Similarly, the General Internal Medicine and Pediatrics programs has been crucial in exposing osteopathic medical students to generalist role models in community and ambulatory care settings.

Through Health Careers Opportunity Program (HCOP) finds, colleges of osteopathic medicine have been able to experience a significant increase in the number of underrepresented minorities.

We strongly support the Exceptional Financial Need Scholarship (EFN) program and disadvantaged assistance programs, both of which reach out to students who would not otherwise be able to afford a medical education.

We also urge continuation of the Health Education Assistance Loan (HEAL) program. Currently 70 percent of osteopathic medical students rely on HEAL, and I am

proud to report that osteopathic medical graduates have the lowest default rates of all the health professions.

The Centers of Excellence program is designed to strengthen the national capacity to educate minority students in the health professions by offering special support to those institutions which train a significant number of minority health professionals. AACOM is proud that the Ohio University College of Osteopathic Medicine was awarded one of the twenty-five Centers of Excellence grants in 1993.

AACOM also strongly supports the Interdisciplinary Training for Rural Areas program and Area Health Education Centers (AHEC). Osteopathic medical education has always advocated a holistic approach to medical care. This extends not only to the patient, but also to collaborative efforts with other health disciplines. These programs have provided special focus to train practitioners to provide services in rural areas, to actually deliver these services to rural residents, and to increase the recruitment and retention of health professionals in rural areas.

AACOM urges continuation of the National Health Service Corps (NHSC) program which awards scholarships to health professions students and assists graduates in repaying their student loans.

Madam Chairman, I have identified the various health professions programs as they are currently configured under Title VII. I would now like to comment briefly on proposals to consolidate many of the programs beginning in fiscal year 1996. In general, if the critically important objectives of all of the programs that I cited above are preserved, if the value of osteopathic medical education continues to be recognized to ensure our fair ability to compete for federal finds, and if adequate authorization of appropriations levels are maintained, AACOM basically supports the consolidation approach. AACOM believes that such consolidation could provide grantees with greater flexibility in managing their programs, as well as stimulate expansion of multidisciplinary, outcome-oriented primary care training.

We would suggest, however, that the national interest of maintaining a sufficient and appropriate number of health professionals to meet the medical needs of all Americans requires continued Congressional support and involvement. Any provision that would simply leave funding priorities within each of the consolidated categories to the discretion of the Secretary of Health and Human Services might subject otherwise valuable programs to cutbacks at the whim of the Secretary. Accordingly, program stability could be compromised. We would urge the Committee to retain an active profile and not give up its priority-determining prerogative to unelected officials. If such discretion is given to the Secretary, we request at the very least that health professions associations specifically be afforded the opportunity to participate in the Department's decisions about what types of initiatives should be supported and at what levels within each cluster.

We would also question the proposal to consolidate the EFN scholarships, Financial Assistance for Disadvantaged Health Professions Students (FADHPS) scholarships, and Scholarships for Disadvantaged Students (SDS) into one scholarship with a service commitment requirement. In our view, these students from disadvantaged backgrounds or from underrepresented minorities should not be steered into particular careers based on theft that they need financial assistance.

Despite these concerns, Madam Chairman, AACOM applauds your leadership in advancing your proposal and looks forward to working with you to ensure that the health manpower is available to meet the health care needs of all Americans.

Again, I appreciate the opportunity to submit this statement. If you have any questions, please do not hesitate to contact me.

Respectfully,

OLEN E. JONES JR., PH.D
Chairman, AACOM Board of Governors
President, West Virginia School of Osteopathic Medicine

THE FLOATING HOSPITAL FOR CHILDREN
AT NEW ENGLAND MEDICAL CENTER,
NEMC #351
March 6, 1995.

The Honorable Senator Nancy Landon Kassebaum,
Chairman, Senate Committee on Labor and
Human Resources,
United States Senate,
Washington, DC.

DEAR MADAM CHAIRMAN: We are submitting this testimony to be included in the record of the hearing on Title VII funding for primary care training.

Maintaining support for programs which provide residency training in primary care pediatrics is vitally important.

With the support of funding from HRSA we have established a primary care pediatric training program here at New England Medical Center. This program has helped to shift the focus of our pediatric residency from tertiary to primary care. The heart of our program is extensive training in Boston community health centers during the three years of residency. One of our program's most important goals is to encourage residents to choose careers in medically underserved urban communities.

We have seen a rapid change in where our graduates go after completing their training. Twenty-seven of the fifty-six residents who completed training in the past four years are in primary care practice. Over one-fifth of these graduates are working in medically underserved communities.

The success we have achieved suggests the importance of this funding not only for our program but also on the national level. For a relatively modest investment it is possible to begin to address the needs for increased numbers of primary care providers.

Funding for primary care training Title VII is particularly crucial in pediatrics because high risk communities usually have high proportions of children and youth in their populations. These young people need primary care provided by physicians specifically trained to care for and advocate for children.

We urge you to reauthorize the funding that supports training in primary care and that this funding be sustained at its current level.

Sincerely,

HOWARD SPIVAK, M.D.
Chief, Division of General Pediatrics
and Adolescent Medicine
Vice President, Community Health Programs
New England Medical Center

The CHAIRMAN. Thank you for participating. That concludes today's hearing.

[Whereupon, at 12:29 p.m., the committee was adjourned.]

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ISBN 0-16-047196-6
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